R.N.

april 1948

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R.N. CONTENTS

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Jo Brown

april, 1948 **vol. 11, no. 7**

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The Doctors' Album of New Mothers

No. 21: SCARY MRS. SPALDING

Right from the first, Mrs. S. was a grade-A alarmist. "Help! My child's *cross-eyed!* Nurse! There's a *hollow* spot on the front of his head!"

And at home—same thing. Mrs. S's doctor learned to shudder when his nurse announced: "Mrs. Spalding on the phone." "Oh, doctor—baby *cries* so. It's a *symptom*, isn't it?" And, inevitably, "Doctor, he's got red spots on his tummy! Is it chicken pox? Measles?"

Calmer mothers than Mrs. Spalding get upset over little external skin irritations common to infants.

Many doctors head off the "distress calls" before they start—by suggesting frequent sprinkles o Johnson's Baby Powder to help *prevent* prickly heat and similar infant discomforts.

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Here are some figures which show how milk prices compare with food prices, from 1939 to 1947:

Increase in cost of food . . . 106%
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Notice that milk has not increased nearly so much as the average of other foods. Our profit from all of our milk divisions averaged less than ½ cent per quart of milk sold in 1947—far less than the public thinks business makes—and much less than the average profit in the food industry.

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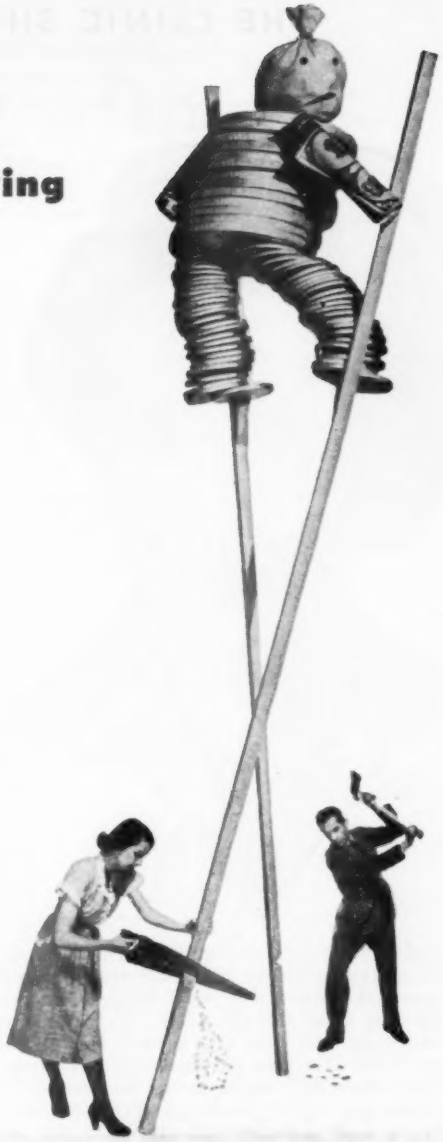

An impartial national survey shows that most Americans consider 10%-15% on sales a fair profit for business. Compared to this, the average profit in the food industry is less than 5%. And National Dairy's profit in its milk divisions in 1947 was less than 2%.

THE CLINIC SHOEMAKERS

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ask the girl who wears clinics

She'll tell you Clinics keep you on your toes long after other shoes have you back on your heels—how Clinic's snuggle-up fit lessens foot fatigue; gives gentle support without cramping. She'll tell you that top-grade Clinic leathers hold their shape longer—are sturdy without being stiff or heavy—and how Clinic's Duflex Nap Soles make each step sure and straight as an arrow.

Then step into a pair of Clinics, *yourself*. Notice how ***smoothly*** your foot slides in. And how smart Clinics look. You'll like the price, too—so remember to buy an extra pair and change them every day. It's more economical because they wear longer—keep their smart, crisp appearance longer.

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DEBITS & CREDITS

Wake Up

Dear Editor:

Where are the nurses? This question is being asked daily. I know where they are—hiding behind a smug mask of self-complacency, waiting for "improved conditions, better hours, more pay, social security, old age pension."

What are they doing about it? Nothing. Professional meetings of great importance are being held in their districts to discuss dispassionately their problems, their complaints, their wishes, and to send representatives to conferences where something can be done.

And what can a delegate accomplish now? Nothing. Why? Because not enough R.N.'s can spare one hour to discuss, weigh and formulate their ideas to enable a delegate to speak intelligently for them in places where their voice could and should be heard.

What a farce to see 19 members at a meeting! Nineteen is a goodly number, you say, but how good with a membership over 260?

Where are all the public health nurses? Are they so satisfied that they do not care to invest in better public health for their communities when they can no longer carry on?

What about the institutional nurses? They complain a lot in locker rooms but fail 100 per cent to complain in the proper places.

Where are the private duty nurses? Now that they are getting $10 for eight hours, have they isolated themselves, forming a group of "isolationists?"

How about industrial nurses and office nurses? Are they a special species that need no help from outside and feel no obligations to their profession? Don't they need social security and old age pensions? Doc-

tors die and plants fold up—remember.

What about the young nurses to come? What has our profession to offer thinking youngsters?

Wake up and act! Be a part of your association, not a parasite living on the life blood of humanity. Attend meetings. Use your voice. Use your time. Use your experience.

LEE ABBETT, R.N.
COVINGTON, KY.

Hobby

Dear Editor:

My hobby is collecting human interest stories, with which every R.N.'s experience is very rich. Won't some of you write me yours—the most dramatic, the happiest, the saddest or the funniest experience you have ever had. [*Turn the page*]

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Painful
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I am particularly interested in the kind of thing that made R.N. of Long Beach, Calif. [June, 1947] write: "I am getting out of nursing and planning a new career where I will feel I'm wanted and appreciated." I sympathize with her wholeheartedly. Many nurses feel just as she does although they express it in different words. Recently I met an R.N. who was selling dresses and she said, "I will never go back to nursing because I believe in life, liberty and the pursuit of happiness."

I believe in these wonderful commodities, too, and I'd like to hear from nurses themselves just what unkindness, what bullying, what belittling experience has brought them to the above conclusions.

V. T. JOHNSON, R.N.
24 CONCORD AVE.
CAMBRIDGE 38, MASS.

"Horsefeathers"

Dear Editor:

I would like to append to the letter of Joseph E. Lorenz [R.N., November, 1947] that the Surgeons General apparently based their statement that, "women nurses working with male patients achieve better results, particularly in the handling of psychotic patients," upon either personal prejudices or political pressure. Certainly the statement is not based on professional studies or beliefs.

The majority of men nurses invest from one to two years in resident psychiatric study, whereas women nurses usually devote an appreciation time of three months in psychiatric affiliation. The statement, there-

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PHOSPHORUS	0.94 Gm.	VITAMIN D	417 I.U.
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The Modess tampon

fore, if applied to the medical profession, implies that the general female medical practitioner makes a better psychiatrist than the male psychiatrist makes of himself. Horsefeathers!

R.N., ERIE PA.

Slip Showing

Dear Editor:

In "A Story Never Told," by Ernest F. Condell, R.N. [**R.N.**, Dec., 1947] the word *breach* was used several times. I was always taught that the word was *breech* . . .

MRS. DORA L. BRUSTEIN, R.N.
ELLENVILLE, N.Y.

[*Sorry,* **R.N.**'s *"breech."*—THE EDITORS.]

Union Bogie?

Dear Editor:

I am sure that we nurses consider ourselves "professional" people. Realistically, however, unless we attain a high economic level, we cannot live or conduct ourselves as such. Sadly enough, most nurses are immature enough to be frightened by words such as "union," "C.I.O.," and "organizing." They agree that the need is present, but grope wildly for a solution that does not use that word *union*. These well-meaning, uninformed nurses ask us to work with our own organizations. As thinking people, they should merely examine the record. These organizations never interested themselves in all-out campaigns for shorter hours, higher wages, and more amenable working conditions. The same record indicates clearly that the nurse's union

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William Stokes
(1804-1878)
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Dr. Stokes thought, as his experiences increased, that others paid too much attention to physical signs, especially in valvular cardiac disease. He believed that the condition of the muscle was more important than the state of the valves. Stokes' contributions greatly aided the advance of medical knowledge in cardiology.

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State.....

has done so and has accomplished much.

I am a young nurse and I have found that many of the older nurses live in an ivory tower of ignorance as far as economics, politics, and world affairs are concerned. I do hope that with present trends I shall in the future be prouder of the calibre of nurses in regard to their insight into vital affairs other than medicine.

R.N., NEW YORK, N.Y.

Suggestions

Dear Editor:

In view of the nationwide nursing shortage, the attitude of hospital superintendents and nurse-directors is beyond understanding. So few of them seem to make any effort to attract young girls into the profession, nor do they take the time to go through their files of graduates and offer them decent salaries for teaching or supervisory positions. Many of these graduates have had experience in teaching and supervision and would be able to teach young graduates and students.

If hospital directors would seek out married nurses in their own town who would be willing to work a few hours a week on floor duty, it would also help to alleviate the shortage.

ERNA ELSASSER, R.N.
UNION CITY, N.J.

Challenge

Dear Editor:

Here are a few rules to help solve the nursing problem:

(1) Only on doctors' orders should

One Treatment exterminates

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Cuprex *The* PERSONAL INSECTICIDE

MERCK & CO., Inc. *Manufacturing Chemists* RAHWAY, N. J.

patients have special nursing during this shortage.

(2) Private duty nurses should feel duty bound to assist their hospitals on occasions.

(3) Petty gripes and gossip should not be tolerated.

(4) Supervisors should develop professional graciousness.

(5) Students should be on an honor system. This would get better results than the rigid discipline which now exists.

R.N., BRECKSVILLE, OHIO

Protection Needed

Dear Editor:

I was sitting in a beauty parlor one day getting my hair done after a very trying day at the hospital of listening to doctors, patients and family-running until I was ready to drop.

A lady customer whom I recognized asked me if I was nursing. She stated, and I quote: "I decided I wanted to do some nursing, so I called the superintendent of the hospital, told her that I wanted to nurse. She told me to report for special duty that night. I was on that case eight days and made $10 per day."

Now, my particular gripe is not because the lady made all of $10 per day when I am only allowed to ask $8, but the fact that a woman who knows absolutely nothing about nursing is allowed to go into a hospital and take a life in her hands, just because her father was a doctor and she had always wanted to nurse (she is now about 65).

As I write this, I look around the

10 minute DRY SHAMPOO

• NO SOAP
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• NO DRYING

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walls of the beauty shop and see the certificates of the operators, and they are not allowed to wash a head unless they are *graduate* beauticians. And yet housewives who decide they want to nurse can go to the hospital and take care of people who have had their anatomies operated on and whose lives depend upon the care they get.

Now I am not asking for protection for myself, but I am asking why the ill and surgical patients aren't afforded the same protection that a woman entering a beauty parlor to have her hair washed has.

R.N., FRANKFORT, KY.

All For It

Dear Editor:

No letter in your columns in many months has expressed my sentiments so strongly as did the one by R.N. of Marshfield, Wis., when she wrote on national registration [**R.N.**, Jan.].

Because I didn't happen to be a female nurse, I couldn't get in the Army Nurse Corps. Yet I was good enough for gun-fodder on the forward lines where I took care of sick and seriously injured fellows—and they didn't stop to ask if I was registered in New Guinea or the Philippines or Japan!

I too think many things should be done in the field of nursing, and one of the foremost is to make legislation possible for national registration so that, as our friend wrote, "A nurse may work in any state so long as she (or he!) pays registration dues."

DAVID CLARK, R.N.
DULUTH, MINN.

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Available Carbohydrates	74.6	73.2
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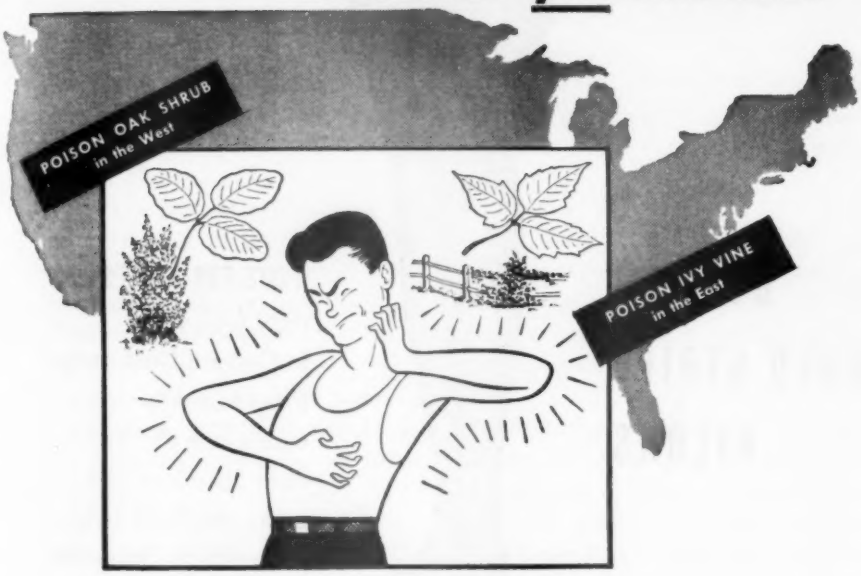

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When your sensitive patients are sensible and ask for protection — a pre-seasonal course of Cutter Poisonok, administered orally, gives the average person protection from 3 to 8 months — and oral administration is much the preferred method of desensitization. It allows you to adjust drop dosage for individual needs — and offers a simple method of prescription for home use. For the refractory case, Cutter will prepare special stronger concentrations, at your request, to enable you to give even the problem-patient protection.

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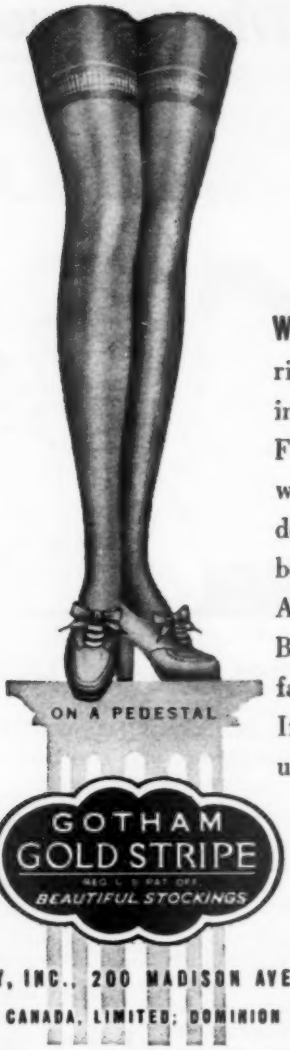

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SCIENCE SHORTS

Poor skin complexion may be due to sluggish starch digestion, suggest two doctors of the Massachusetts College of Pharmacy. In experiments, a given quantity of starch was digested within six minutes in persons with clear skins, whereas starch digestion took up to one hour for persons with skin eruptions.

In some cases of sudden deafness in older people attending the Mayo Clinic, histamine injections are proving beneficial.

Cows may soon be dosed with one-a-day vitamin pills. According to Drs. Hickman, Swanson and Harris of Distillation Products, Inc., the quality of milk can be greatly improved with the addition of concentrated vitamin E to the animals' diet.

Leukemia takes more than 6,000 lives annually and is the leading form of cancer among children, reports the Metropolitan Life Insurance Company. Its mortality rate is more than five times that of infantile paralysis.

A new use has been discovered for the male hormone, testosterone, by a California Medical School research group. Tried on 100 premature infants, it was effective in increasing their weight and strength and they matured faster than babies from whom the hormone was withheld.

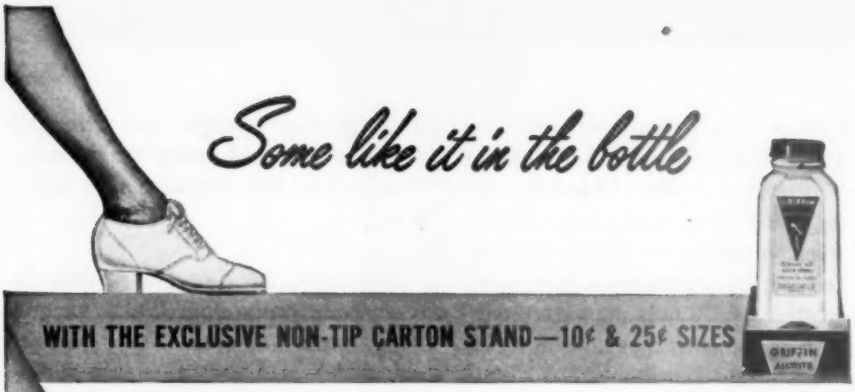
Drs. Roh L. Kile and Aston L. Wels have found that liquid oxygen is effective and easy to use for removal of warts and other non-malignant growths.

Four doctors report in the *JAMA* a 77 per cent survival rate for cirrhosis of liver patients after treatment with crude liver extract. With no strict supervision of diet, the patients were urged to select foods high in protein and carbohy-

drate. Among the beneficial results were: a return of appetite, sense of well-being, diminished fatigability and relief of ascites.

In an article published in California Medicine, *Dr. Thomas F. Mullen stresses that gastric cancer must be suspected in every patient who complains of mild digestive symptoms.*

Dr. Anthony Bassler presents, in *Digestive Diseases,* a new symptom for gallbladder diagnosis. Upon gentle palpation, there is a marked fullness or a slight to moderate degree of resistance directly below the costal margin on the right side.



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R.N. Speaks: CITIZENSHIP

III. Responsibility

As the ANA house of delegates is the supreme legislative body of our incorporated association, every action taken by the House is binding. The ANA speaks for the entire nursing profession; therefore, whatever resolutions are made while the house of delegates is in session, the association and all its members are committed to abide by such decisions. If a decision has been ill-considered, it can be rescinded only two years later at another regular meeting of the house of delegates, or in a special meeting called "upon the written request of 15 or more constituent state nurses' associations" (art. 11 sec. 2). At the September, 1946 Biennial, for example, the house of delegates voted to take certain action regarding the structure report. The ANA legal advisor interpreted this action to mean that the ANA could not participate actively with the five other nursing bodies in pursuing the consideration of the report. One year later at a special meeting, the House voted to remedy this situation. It could not be remedied without action by the House which had taken the original action.

Every nurse appointed to serve as delegate to the 1948 Biennial must realize this sobering fact. Her vote may be the decisive one in approving or rejecting proposed actions that will bind the profession to certain activities. She does not attend the convention primarily for a vacation, nor just for the ride. Her business is a highly responsible one, especially so in this critical era in nursing affairs.

Every delegate has a two-fold task. First, to inform herself in advance of the sentiment in her district on the issues that we know will be considered by the House. Second, before casting her vote, to inform herself on the new, unannounced issues that come up for action during the convention.

By the time this is read the ANA will have issued its call to meeting to the state nurses' associations. At the present moment, we do not know what issues will appear on the agenda. Two are definitely scheduled for discussion: revisions of the by-laws and the recommendations of the Structure Committee.

The March *American Journal of Nursing* lists the proposed changes in the ANA By-Laws in columns contrasting them with the present

of a delegate

ones. The proposed changes appear in italics in right hand column. They merit close study for their purpose is to increase efficiency. The Board is increased from six to eight Directors; a standing committee on credentials is created; Negro nurses, unable to join state associations will be admitted directly to the national.

A new one-organization plan is advocated by the Committee on Structure. In contrast to the earlier plan which placed emphasis on *national* set-up, it focuses thinking and action first on the *district*. The Committee made the sound decision "that its first task was to find a form of local organization that will meet the needs of nurses where they do their work, and meet nursing needs of the community, and build state and national organizations on that." It is most important that delegates understand the significance of this local emphasis in planning our national structure. Eight supporting premises are offered by the Committee for district discussion. The delegate who will vote on this approach to our structure problem must be fortified by an understanding of district opinion, and only through district discussion can that opinion be arrived at.

The nature of the discussion by the house of delegates on both by-laws and the structure plans cannot be predicted. Hence the instructions given delegates cannot be hard and fast. The delegates must depend upon their common sense; upon the state caucuses often held on the spot; and upon their knowledge of how the nurses "back home" feel about the general issues involved. *Unless the delegate does everything in her power to represent the nurses for whom she is voting, she is depriving them of their rights as members.* In the matter of the new, unannounced issues that are presented for delegates' decision, we urge that before our 1950 Biennial the printed booklet with reports of our officers, executives and committees be issued well in advance. The recommendations emanating from these groups are often far too important for the consideration they must get from a hasty reading or explanation from the floor. Many of them merit preliminary discussion in the districts. Furthermore, the questions that arise in nurses' minds from a study of the reports more [*Continued on page* 54]

CANDID COMMENTS

WE POINTED OUT in March that economic security alone is not sufficient to restore nurses' faith and loyalties. The subject is so important that we explore it further. Low wages for nurses persisted long not primarily for lack of money. *It persisted because we of the profession did not put a higher evaluation on our work.* The deeply rooted idea that the nurse herself was unimportant, only her work was, arose within nursing, not without. It was a highly contagious idea, however, quickly caught by others. Until this attitude and all the roots leading away from it are torn out and replaced by an appreciation of the dignity and worth of the individual, getting more money will simply mean higher wage and little else.

Nursing needs what the world needs, new thinking. The world needs new ideas to combat extreme nationalism and old prejudices. A new concept of the worth of the average man of all races is needed. New ways for humans to get along together in peace must be devised. "A new type of thinking is essential," says Albert Einstein, "if mankind is to survive and rise to greater heights."

Nursing must replace the militarism that divided us into "command-obedience" ranks with a cooperation that recognizes the dignity and value of the average nurse. The average nurse needs to attain a greater maturity in her grasp of nursing's responsibilities. More is involved than wages, hours and locker arrangements. We need these things both in our daily jobs and in our professional organizations.

Nursing is in its present grave situation because of wrong attitudes. In my private duty days, for example, it was commonly understood that "nurses are trained to go without sleep." It took years of struggle with our own people and the public as well to achieve the shorter working day. Today, the public cheerfully pays 80 per cent of the costs of its state universities, yet approves a system of nursing education that must be paid for largely through student tuitions and toil.

There are other equally wrong attitudes, but the one I believe to be the springboard for all others relates to our rating of the nurse herself. Years ago a shrewd observer commented, "Until your profession places more value on the worth of its own graduates, you cannot expect the

"LET'S TALK IT OVER"

by Janet M. Geister, R.N.

public to do so." The nurse's work counted high with us, but the nurse herself must realize that "nursing is a life of sacrifice." We didn't mark the line between needful and needless sacrifice.

Two factors, in my opinion, are responsible for this attitude. In the years when almost 2,300 schools were turning out graduates faster than they could be profitably used, it was easier to replace nurses than to preserve them. Mass production of any article decreases its intrinsic value. A more potent factor, however, was the distortion of the fine old tradition of obedience at the bedside into a form of control that permeated every area in the nurse's life. Time and again in the past we heard, "I'd rather have a school than a graduate staff. You can control students easier. They don't ask for so much."

Into the maw of "control" went personality, initiative, personal rights. The nurse who spoke too frankly at district meeting sometimes found it hard to get work. I knew good nurses who refused committee work for experience had taught them "to keep our mouths closed." Rules were made by our betters—we simply must obey them. We must be satisfied with what we get. The nurse with ideas got "sot on"—the one with a complaint was a "trouble maker."

The cure for these attitudes that arose with us must begin with us. All true reform begins at the heart. No enduring help can come from the public until we are ready to make that help support our major reforms. By the end of 1948, the United States Government will have appropriated $182 million* for nursing education. For all that money have we made proportionate advances?

Money is important but it does not buy morale, confidence and teamwork. Men don't work for money alone. Albert Walton** says men

work for three reasons—personal benefit, peace of mind and complacency. In other words, we work to pay the rent, to find satisfactions in doing a job well, and to feel our work has made a contribution. Nurses resented the small value put on their services more than they resented the small checks. The practice of treating nurses like cogs in a machine hurt self respect. Every human craves recognition of the value of his work. When hospital care insurance filled the beds constantly and nurses' case loads precluded good work, morale shot down. The last stronghold, satisfaction in good work, was gone.

These attitudes have cost us dearly. Today in our need, we are short of experienced, young leaders. Too long have the many simply followed the routes laid down by the few. We are mature in patient care, but the mass of us are tragically immature in handling professional affairs and comprehending major issues. We are sorry for ourselves, or bitter, or rebellious. Last year 30,000 nurses got their first state licenses, but the ANA lost, instead of gaining, members.

Our big job of re-education lies first within nursing. We must reestablish confidence, restore morale, create an abiding sense of our spiritual unity. New thinking is absolutely essential not only by the statesmen but by those in the ranks. Participation by all for all is the order of the day. President Truman's Commission on Higher Education urges two years of college at public expense for all young people because the peace of the world depends upon how well the average man understands its problems.

We have ample power within us to solve our major problems. Mankind must always grow up to its challenges. Diamonds don't grow on trees; new ideas must be mined out. We begin with recognizing the worth of the individual. The nurse is not only a service agent; she is a person, one of the family, not just "hired help." She must achieve adulthood in every area. The professional dignity and value of the group and its practitioners are indivisible—the group cannot gain its full stature until its members do.

One of the most direct ways of breaking down barriers, stimulating thought and establishing mutual respect is the "discussion method." Community groups, such as the League of Women Voters, farmers' organizations, civic, religious, industrial and educational bodies, are finding this method most fruitful in creating the new ideas our new world situation demands. It is simply the old neighborly talking things over, with techniques that make it dynamic and productive instead of just a gossip or gripe session. It is a forum without a platform or speaker, but with an intelligent leader who keeps the discussion in hand.

This form of talking things over brings in everyone concerned with the subject, and all on the same level. The right and duty of every member to express opinion is its foremost ingredient. Its prime purpose is to stimulate thinking. When we put our own ideas to the test, when we learn

those of others, we can clarify issues and find the basis for sound action.

I know of no better way to begin our re-education than this. Nothing in the world can bring a team alive so much as sharing the responsibility of shaping policies and plans. Loyalty springs from a sense of belonging, and nothing else. It is amazing to realize what strangers we are with each other! Doctors, hospital and health administrators, nurses, all share serious work, but rarely do we have a planned interchange of ideas.

The place to begin our new thinking is not at National Nursing Headquarters, New York City, but right where the nurse works and lives. That is where the issues are and that is where the people are. Not one of us, or a thousand, can do the whole job, but each can do what he can. And in the end that is what is important.

The profession never has had greater opportunities and responsibilities than now. The professional nurse is absolutely essential to the successful work of hospitals, health agencies and in the modern practice of medicine. The demand for nurses increases as our citizens demand more health protection. Our responsibility is to cut away hampering ideas and bring forth the new ones that will develop our full, adult powers. Then we can meet the challenges of the day with a spiritual unity that can overcome all obstacles, and help us to rise to greater heights.

*Facts About Nursing
**"New Techniques for Supervisors and Foremen"

Your Delegate's Expense

How much should the state or district pay official delegates attending national or state conventions?

One delegate who trekked to Atlantic City found that her expenses totaled $425 while the district allowed only $350 for expenses. A western delegate estimated that a trip to the east coast convention cost her $600 when she added in salary lost while away. Westerners, for the most part, would like to see conventions more centrally located—at least part of the time.

State delegates report an average allowance of from $15 to $20 for a three-day meeting. Official meal tickets, on the other hand, present a different picture: $1 for breakfast, $1.50 for lunch and $2 for dinner. This leaves the delegate with half a dollar to juggle between transportation and hotel if she is allotted a $5 a day stipend.

Even the civil service allowance of $6 a day admittedly does not cover away-from-home costs.

Delegates' "expenses" just do not cover costs and, if there is good reason why this can't be remedied, at least a vote of thanks can go to those willing to make personal expenditures for the good of the profession

RUTH B. SCOTT, R.N.

WHY AMERICA IS ASKED TO "HAVE A HEART"

"HAVE A HEART," the lady says, holding out a round pasteboard box for your coins. She is saying this, not only for the one million Americans afflicted with rheumatic fever, but for the scientists who need public support if they are going to lessen the appalling total of 40,000 yearly deaths from this incapacitating disease.

Rheumatic fever does strike persons of all ages but its chief victims are youngsters. Excepting accidents, it is the greatest killer of school children and ranks as the second most important cause of death in the 20 to 24 age group. Rheumatic fever also rates high as a chronic disabler—two-thirds of all its victims will sustain some permanent injury to the heart and many of them will have to lead restricted lives.

What is this disease that can seek out and cripple so vital an organ as the heart? What are the chances that science will be able to cut down the death toll? The accumulation of facts on rheumatic fever has been slow and painful and the medical theories have been ever changing. One hundred and one years ago a young woman was taken to a Massachusetts hospital suffering with swollen joints and a fever. She got steadily worse despite the series of treatments which ran the gamut from elixir of opium to rhubarb and soapsuds. When her rapid decline became complicated by severe psychosis, the authorities discharged her—to an insane asylum. Science has made many worthwhile advances since that time but a full understanding of cardiovascular diseases is yet to come, perhaps in the next 25 years.

Rheumatic fever is chronic, and scientists have lately come to believe that it is due as much to social factors as to the streptococcal infection that usually precedes the disease. Its victims come generally from poorer homes where crowded living conditions and inadequate diets take a high toll in crippled hearts. It most often occurs in children between the ages of five and ten, and young adults who get the disease invariably have a record of rheumatic infection in childhood.

The disease usually starts with an infection of the upper respiratory tract and may be so slight as to escape detection until three or four weeks have passed. The rheumatic fever symptoms can then take various forms which often accounts for much difficulty in diagnosing the disease for what it is. How, for instance, are parents to know that "failing health" may actually be the onset of rheumatic fever. Their youngster has a sore throat, appears tired and fatigues easily. Pains localized in the joints are often set down to "growing pains" and the young victim is often

considered not sick enough to go to bed. Another mode of onset, more readily recognized, is manifested with multiple arthritis accompanied by high fever, subcutaneous rheumatic nodules, carditis and pericarditis and even heart failure. Tachycardia and cardiac murmurs as well as chorea are also sure indications of the disease.

There are actually no characteristic symptoms of the disease, but pain in the joints and a continued fever are common. It attacks the connective tissues of the body and causes a focal inflammatory reaction in the muscle, valves and outer lining of the heart. There is no single, conclusive test for the disease and actual rheumatic fever cases can slip past blood tests or the fluoroscope and electrocardiograph. Doubtful cases nowadays are rigorously followed up to the point of positive or negative certainty.

When the inflammation of the initial attack subsides, the permanent effect may be slight or serious scarring of one or more of the four valves between the chambers of the heart. Small scarring, fortunately in the majority of cases, means that the patient may continue with a normal life or with little restriction, if any. More serious scarring usually means perhaps complete recovery from the initial attack but more serious damage with succeeding attacks. This possibility indicates that the best possible care is needed for the rheumatic fever victim. Within recent years doctors have come to know a great deal more about preventing these recurrent attacks, but the knowledge has not been widely spread because rheumatic fever has not yet been fully recognized as an important public health problem.

Much of the theory concerning rheumatic fever is necessarily still in the conjecture stage, and on various points different groups of doctors split sharply into opposing camps. More and more, though, they are all agreeing on one point—less concentration should be put on developing therapy for the already damaged heart, and more, much more, time needs to be devoted to treating and preventing the causes of rheumatic fever and all the heart ailments. Dr. Paul D. White, clinical professor of medicine at Harvard, has said: "We must take the people into our confidence and tell them how little we actually know about the chief causes of heart disease though at the same time we should urge their *patient support* of our future efforts, particularly in fundamental clinical and laboratory research."

One point where the medical men haven't reached anything like agreement is on heredity. Readily obtainable facts show conclusively that there will be a greater tendency toward rheumatic fever in families having histories of the disease. One group of doctors holds firmly that this is easily explained by environmental conditions. The other group, and perhaps more representative of the present prevailing opinion, believes just as firmly that a susceptibility to rheumatic fever can be inherited. The chances are more than three to one [*Continued on page* 80]

REST IS PRESCRIBED

by Lura L. Frati

"REST, REST AND MORE rest" was the way one physician summarized her suggestions for the nursing care of rheumatic fever patients. Closely allied to this is the thought that a happy child more quickly regains his health.

There are many factors to be considered to insure a rheumatic fever patient the rest he needs and the activities to make him happy since the length of his illness may stretch from weeks and months into years.

Three stages, in reference to nursing care, will be considered here: acute, sub-acute and convalescent. First, hospital type nursing with complete bed rest is stressed during the acute stage; secondly, in the sub-acute stage, the nursing care is continued and educational and handcraft activities, appropriate to the age of the patient and ability, are added to his program; thirdly, during the convalescent stage, education should be stressed, and as much physical activity as is approved by the physician.

Along with complete bed rest and hospital type nursing, spoon feeding, bed baths and, in the most acute cases, an oxygen tent, are essentials in the acute stage.

Since rest is so important it is essential that the patient have a comfortable, firm bed. If the springs sag they can even be tied with cord to make them more firm.

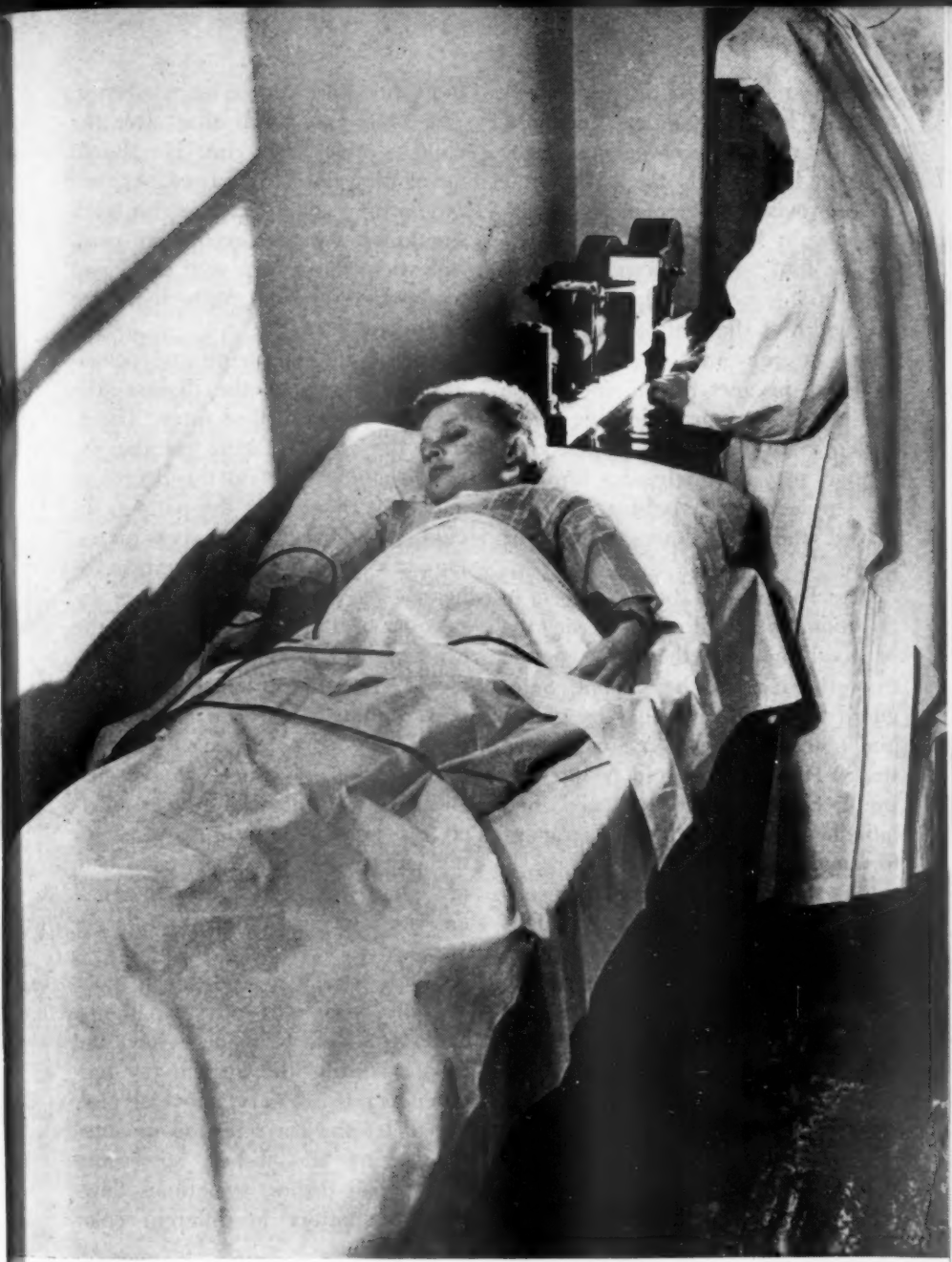
The bed covers should be light but warm and up on the sides of the bed to avoid weight on the patient. The sleeping garments should follow the same rule, warm but light, but never tight enough to prevent free circulation. Full length pajamas, fastened down at the ankles, prevent exposure of the patient's legs.

Since rheumatic fever patients are subject to "sweats" the bath water should be about 80° Fahrenheit, and the room must be warm. If the bath is given between 4 and 5 o'clock in the afternoon when the patient's temperature is likely to be highest, it will make him more comfortable and insure him a better night's rest.

Again, because of the sweats, care should be taken to dry the body thoroughly, giving especial attention to the creases and between the toes. Dust the child's body with talcum. It isn't necessary to use an alcohol rub if the child objects to the odor. When the bath is completed, cover the patient and air the room.

During the sub-acute stage, determined by a doctor's examination, the patient gradually regains full activity in bed and, if old enough, is allowed to bathe himself. But still he needs nursing care, and is not permitted lavatory privileges.

The patient, sitting up in bed,



From Three Lions

Facilities for electrocardiographs and necessary bacteriological research are provided at St. Francis Sanatorium at Roslyn, N.Y., where both "active" and "quiescent" rheumatic children are accepted.

needs firm support both for the back and the feet and under the knees. The foot rest reduces weakness of the muscles in the legs. Back rests may be improvised from materials available in any home.

The foot rest for a patient confined to his bed should extend the full width of the mattress, or a little wider, to prevent the patient from thrusting his feet to the side of the rest, and should be adjustable to the patient's position in the bed. A knee support may be made of a firm pillow, rolled, or a bolster may be placed under the knees to support them.

The bed should be so placed in the room as to follow the basic rule of good lighting; the light coming from the rear of the patient. Safeguard the child's eyesight by giving him objects that will not cause eye strain. Particularly avoid books with small print. A well-adjusted bed table helps to make the child content to remain in bed.

The rheumatic fever patient needs 10 to 12 hours of sleep every night plus a rest of from one to two hours every afternoon. The nature of the disease makes the patient restless but the rest period should be as regular as clock work. At the same time every afternoon, the window shades should be drawn and nothing should be allowed to interfere with the rest period.

Even under the most ideal conditions, the treatment of rheumatic fever is a long wearisome business. It is especially important not to let the patient become tired. At the first indication of fatigue he must rest. The same rule holds true after the child is able to be up. He should never play until he is tired. As well as guarding against fatigue, his teeth should be watched even more carefully than those of a well child and toothaches reported immediately to the doctor.

During the sub-acute and convalescent periods of the disease, the doctor does not call as often. Therefore, the person caring for the patient should report to the doctor at once any changes in the patient, including such findings as spots on the patient's body that look like bruises; headaches, as frontal headaches are peculiar to the disease; or cold in the head or throat. These signs may indicate a flare-up of the disease.

A rheumatic fever patient needs plenty of good nourishing food, paying attention, of course, to personal allergies. Considerable fluid is needed and possibly a little extra salt to replace the loss due to sweats. One physician suggested five or six small meals a day rather than three larger ones.

Since there is a tendency to poor appetites in rheumatic fever patients, an effort should be made to have the food as tastily and attractively prepared as possible. Try, above all else, not to let the trays be too monotonous. Vary the dishes, sometimes using plain dishes, sometimes flowered, or pottery in different color combinations.

During the sub-acute and the following convalescent or limited activity period, [*Continued on page* 56]

by Phayre Peck, R.N.

I KNOW THAT I am not the only mother who has cared for her sick children; however, I have just nursed my two little sons through a stormy seige of rheumatic fever, and I fervently thank the Lord for the wonderful training that made me a nurse.

It was truly a bleak day that rainy Saturday back in September, 1945 when my oldest boy, who had started school two weeks before, awoke feeling sick. By afternoon, he really looked and acted so ill I put him to bed and called our doctor. Although the child's temperature was only 100° rectally, he appeared as if it were much higher. The doctor examined him, found one leg quite stiff and resistant to movement, and detected a definite heart murmur. Since he had all the indications of rheumatic fever, the doctor ordered him kept as quiet as possible until a positive diagnosis could be made. Laboratory work, which included a sedimentation rate and a complete blood count, was ordered for the following Monday to confirm the diagnosis.

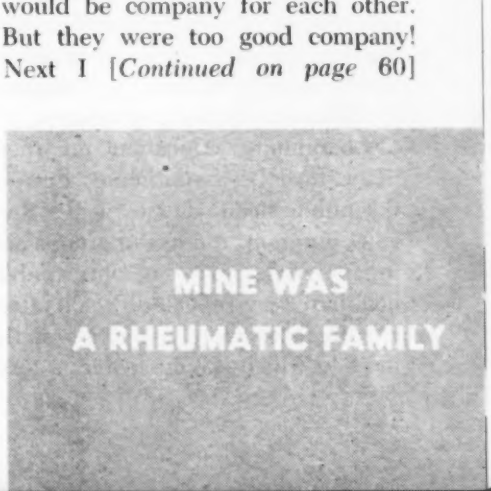
I simply counted the hours till Monday. When Monday dawned, my youngest son, just past three, awoke with an elevated temperature. I again notified the doctor. She came, examined him, and then—laboratory work to be done on two boys instead of one. The tests verified her diagnoses on both children—RHEUMATIC FEVER.

It was very hard for me to accept the verdict that both my boys had rheumatic fever but I tried to accept it as I would were I on a private case. When it is your own children it is not so easy. I knew I would need every bit of courage I possessed to face what lay ahead.

The difference in this type of nursing and private duty nursing is that a mother's shift isn't over at the end of eight or twelve hours. It goes on day after day, from week to week. The weeks stretch into a year and often more. I know now what it means to feel as though one might as well be living somewhere on a desert island. I felt so isolated and left out of things. But it is truly a soul-satisfying job to watch your children come back from sickness to health, to see the color return to pale cheeks and the sparkle come back to listless eyes.

With my two little boys in bed it seemed as if I never could accomplish everything. Sometimes the housework piled up. At other times it seemed as though my whole world would collapse. Those were my low, low days.

At first we had the boys in the same room, for we thought they would be company for each other. But they were too good company! Next I [*Continued on page* 60]



SPOKANE'S PUBLIC HEALTH NURSES' ROLE IN RHEUMATIC FEVER

by Ruth B. Scott, R.N.

BECOMING ALARMED in 1939 because rheumatic fever was reported as a leading cause of death, the Children's Bureau, at that time in the Federal Labor Department, allocated funds for a rheumatic fever control program in selected areas.

Spokane, Washington, was selected as one of the original areas for the Federal-state program of rheumatic fever control. The Spokane County Public Health Nurses, with a progressive organization, were well-equipped to play a major role in this program.

The first Rheumatic Fever Clinic in Spokane was held in November, 1941, and seven years later Dr. Frederick Fischer, clinician in charge of the rheumatic fever program, had occasion to announce proudly, "Our nursing program was pronounced outstanding by national investigators of all rheumatic fever programs."

Community education on rheumatic fever is a continuous duty of the public health nurses in the Spokane program. In talks to groups and in conference with parents, public health nurses repeatedly call attention to those early symptoms of the ill child which should require a thorough medical examination. The object of this education is the early recognition of complaints of fever, fatigue, irritability, poor appetite, leg aches or other conditions which may be associated with rheumatic fever before they reach the acute inflammatory stage with obvious heart involvement.

Case finding by public health nurses goes on at the schools, at the Well-Child Clinics which are held at 16 County Health Centers and on all public health nursing calls. The purpose of the case finding by the public health nurses is not to diagnose rheumatic fever but to find the ill child and make sure that he sees a doctor.

Parents who can afford to pay are referred by the public health nurses to their private physicians. Private physicians may request medical consultation by referring their cases for examination to the pediatricians of the Rheumatic Fever Clinic.

Parents who cannot afford private care are referred to the County Health Department where the health officer takes the medical history and gives the children their initial physical examination and laboratory work. Children, screened as possible rheumatic fever patients, are referred to the Rheumatic Fever Clinic. Public health nurses who have been case-finding see these children again when they assist with preliminary examinations.

Miss Mayme Hudson, supervisor of the Spokane County Health Nurses, says: "I find three public health

nurses are necessary to a smoothly running clinic when two doctors are conducting examinations. I assign two county nurses and request one nurse from the city schools or the city visiting nurse service."

In addition, the clinic may have basic nursing students from three city hospitals who staff both the girls' and boys' dressing rooms and bring each child into the examining room; graduate nurses who are taking a public health course; a nutritionist; a medical-social worker; a medical secretary; and several volunteer women who serve as receptionists.

Laboratory work must be completed before the clinic doctor sees the children. A routine large chest x-ray is taken on the first visit. On every visit, urinalysis, red blood count, hemoglobin and sedimentation rate are prepared. During the clinic, the doctor may request a check for undulant fever or tuberculosis, and order various x-rays.

Public health nurses always have a pre-clinic conference with each mother or guardian, who is required to accompany the child to clinic. At this pre-clinic conference, the public health nurse questions the mother about the child's appetite, sleeping habits, and any pains since the previous clinic visit. She writes these notes on the history, and any other information which may help the doctor, including questions parents may wish to ask the doctor.

The clinic examination is not only a complete diagnostic service for all pediatric problems of child and parent but an excellent teaching clinic for all who sit in the examining room —public health nurses, basic and graduate public health students and the head of the pediatic service of the hospital. An intern may also be present to profit from the clinic.

Complete frankness is the unwritten law. When a student public health nurse brings in the child and mother, the doctor examines the child and dictates medical findings to a medical secretary. He discusses the child's condition in lay terms with the mother, asks her for information and answers her questions.

Children listen while the doctor dictates, "Murmur about the same," or "Murmur much less than at acute onset." The pediatrician explains that a heart condition is something a child has to learn to live with; children respond well when they are treated honestly. "We take children into our confidence at the earliest age on heart [*Continued on page* 70]

NURSING in the BELGIAN C

WHERE VOODOO, RELIGION, AND SCIENCE MI

GEORGIA BATEMAN, R.N., is just five feet tall but when she first started to visit the homes of her patients she had to stoop to get through the doorways! This sounds strange to our culture but it isn't really so strange when you place Miss Bateman in the locale in which she has carved out a nursing career. The patients' homes she began visiting 21 years ago were mud houses in a section of the African Belgian Congo where the Congo River crosses the equator for the second time. This hot, humid section very nearly could be called the "heart of darkest Africa" if it were not for the fact that the Belgian Congo now abounds with missionaries—3,952 of them bringing enlightenment.

Miss Bateman is one of those missionaries, and the enlightenment she offers is the constant beam of her Nightingale lamp. While nursing is still foremost in her life, it is actually just one of many tasks she has set for herself in a busy web of days where work habitually starts at 5 o'clock in the morning and continues until 9 o'clock at night. Among her other teachings she has, incidentally, helped to convince her mission people that they should build taller houses with windows in the rooms, eliminating the stoop doorways.

Georgia Bateman's life devotion to missionary work began in 1916 when she volunteered, through her church, for work in the mission fields. She was graduated from college a short time later and chose nursing as her further course of study because there was then, and still is, a desperate need for nurses in many of the out-

CONGO

MEET AT THE BEDSIDE

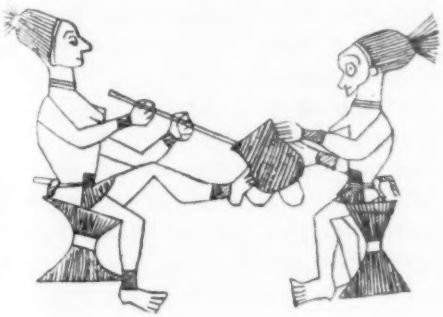
by Dollie C. Carpenter

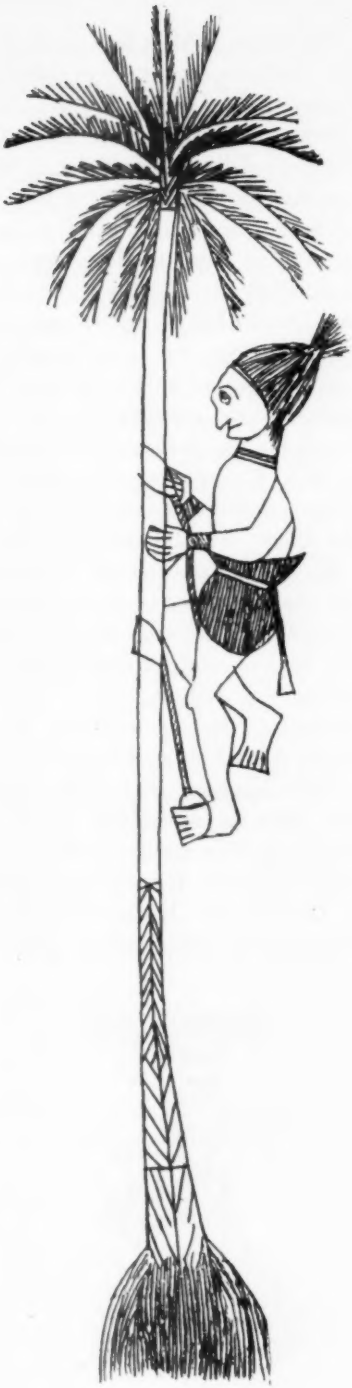
of-the-way places. She was graduated from the Methodist Hospital in Peoria, Illinois, in 1923. Four years later she was in Africa helping other missionaries of many faiths and nationalities wage war on such variegated and age-old enemies as leprosy, malaria, intestinal parasites, tuberculosis, venereal disease and superstition. Chronic skin ulcers of ten years' standing were not uncommon, she discovered, and tuberculosis and venereal disease, imports from western civilization, were and still are on the increase.

Superstition, a man-made enemy, is perhaps the most stubborn to eradicate and Miss Bateman, after two decades, is still pitting her knowledge of modern medicine against voodoo charms and cures.

Obstetrics actually takes up the

Pictograph carved on ivory horns, photographed from the Belgian Congo collection, American Museum of Natural History, New York.





greatest share of Miss Bateman's time and it becomes especially problematical due to the lack of doctors. Most of the nurses in the Congo are called upon to do deliveries unassisted. Miss Bateman's maternity ward in the hospital is a strange, necessary mixture of primitive and modern methods and equipment. The beds are metal frames with board mattresses and grass matting to supplement a meager supply of rubber sheets. The hospital is not equipped to do the cooking for the patients, so each patient has a caretaker who may be husband, mother or near relative. At night these "caretakers" bed down on the floor between the patients' beds. Most mothers insist on keeping the smoky lanterns under the mosquito nets at night to keep an eye on their new babies.

Delivering babies wouldn't be so difficult, Miss Bateman points out, if she didn't have to combat the superstition that is attendant on every pregnancy. The native women still believe in certain types of evil spirits that must be guarded against. These beliefs govern their eating and activities. The pregnant woman denies herself a special food and sometimes the dietary taboos even extend to the husband. For instance, the meat of a leopard is forbidden to both the pregnant woman and her spouse.

The native people often call on Miss Bateman to act as an arbitrator. One evening, she related, she was awakened from her sleep by the cries "Am I not the sentry?" She hurried out into the hospital yard to find a group of new mothers and some of their husbands in the act of flailing and beating an old man. The poor old fellow was actually the sentry but it took a good deal of convincing by Miss Bateman to assure the crowd that he was not an evil spirit come to take away a new child. She says he did indeed look like a spirit from another world, wearing a long scarecrow coat and having his legs and head wrapped in rags as mosquito protection. He carried a vicious knife and spear, and incongruously played a quaint music box to keep himself company on his tiresome, nightly rounds.

It's hard to imagine subjecting an American woman to ten hours of paddling in a canoe before reaching a hospital for the birth of a child—Miss Bateman's patients often travel this far or more. They usually come to her famished and refusing to partake of food or drink until the child is born. If labor lasts for three or four days, they neither eat nor drink for that time. If the labor seems too protracted, they unbraid their hair in some ritual supplication.

No more reasonable is the super-

stition dictating that a woman may not carry a heavy load during the middle months of her pregnancy but may carry as much as her husband desires her to carry during the last two months.

A successful birth is a joyous occasion for the community where the maternal and infant death rates are still far too high. When the mother and child both live, a friend often runs down the road announcing "She lives, she lives." If the husband bears the good tidings he is more likely to shout "I live, I live."

The station, facing the Congo River, is surrounded by tropical rain forest which must be fought back continually. Duty begins for Miss Bateman in the Bolenge Coquilhatville hospital at 5 a.m. Her 6 o'clock medicines are given to her patients before the arrival of her class of native student nurses who receive instruction from six to seven. With her morning class out of the way, she puts out food for the native orderlies and plans their work for the day. At eight, she turns to dispensary work which occupies her time until lunch. In the afternoon, she teaches a hygiene class at the Bolenge school and gives more class instruction to her student nurses. Before her evening meal, she must dispense medicine again and prepare formula milk for orphaned children. What happens to Miss Bateman's evenings? She uses this time to teach obstetrical work to her advanced student nurses and in translating English nursing texts into French and Lonkundo, the native language.

Patients come to the hospital from 30 miles in all directions with an average of 250 dispensary patients a day and 30 in-patients. In the vicinity there are also a few small dispensaries, a state hospital and a leper colony.

With the insistence and teaching of the missionaries, the native diet is fast becoming more scientifically sound. It formerly consisted mainly of the root of the casava plant for starch, and the leaves of the same plant cooked in palm oils for the fats and greens. Now they are learning to raise and eat beans, peanuts, corn, and a few will eat tomatoes. They also have fruits, native to the Congo —papaya, oranges, mangoes, bananas and pineapples. The greatest dietary problem, Miss Bateman says, is milk for the children. The babies thrive until they are weaned and put on an adult diet. Then they soon show the same vitamin deficiencies as their parents. Cows will not live in the Congo because of the sleeping sickness carried by the ever present tsetse fly.

If cows [*Continued on page* 66]

CALLING ALL NURSES

NURSES WHO WOULD LIKE *to locate friends whose addresses have been recently changed or become lost during the past few years may submit for publication, without charge, a short notice of not more than 75 words "calling" for information about any other registered nurse.*

LT. DORIS Y. EVANS, ANC: Last known address Fort Huachuco, Ariz. Have written you but no response. It would be wonderful to hear from you again. Georgia Pollard Scruggs, 1365 Lyman Place, Bronx 59, N.Y.

MARION J. RICE: Would like to know what happened to you after you left Van Nuys, Calif. Believe you were discharged in April 1946. I'm still waiting for your promised visit. Dorothy Davis, 41 Catherine St., Ilion, N.Y.

GRADS OF AMSTERDAM CITY HOSPITAL: Help your Alumnae Association to bring its record up to date. Send your name and address and that of any other graduates with whom you've kept in contact to Miss Phyllis Ulrich, Alumnae Secretary, 50 Greene St., Amsterdam, N.Y.

O'CONNOR SANITARIUM ALUMNAE: Send us your latest name and address. Don't miss out on the many wonderful things being planned for our Golden Jubilee, early in 1948. Send the names of other members that you know, too, so they will share in our great celebration. O'Connor Alumnae Association, c/o O'Connor Hospital, San Jose, Calif.

JO BALLA: We had our basic training for the ANC at San Antonio Aviation Cadet Center. I have married since you wrote from France. Would love to hear from you again. Emma Joan Knoll Wiberg, 54 W. 21st St., Chicago Hts., Ill.

LT. KATHRYN O'BRIEN: Formerly at Pine Camp in 1942 and later with a Station Hospital in North Africa. Lost your address and would enjoy hearing from you. Miss L. McCormack, Veterans Hospital, Rochester, N.Y.

R.N. FANS: I have many back copies of R.N. If you would care to have them, please write to Erma Clopton Armstrong, Box 709, Mount Shasta, Calif.

R.N. COLLECTORS: Are you interested in back copies? I have almost all issues back to December 1942 and will be glad to send them on, postage postpaid. Evelyn K. Groff, 2314 Russell Rd., Muskegon, Mich.

I'll send mine too. They go back to February 1945. Ada Mae Parker, 5034 Agnes Ave., Kansas City 4, Mo.

GEORGIA E. BICHY LANE: Originally from Baltimore, Md. Worked at the Cradle Society in Illinois in 1938. Remember the days we worked together at the Strong Hospital? It was nine years ago and I've missed you. Rose Sico, General Delivery, Little River, Miami, Fla.

JEAN HENDERSON: Graduate of Shadyside Hospital, Pittsburgh, Pa. Lost your Oregon address and would like to hear from you. Sally Kerr Page, 412 N. Madison, Rome, N.Y.

EX-ARMY AND NAVY NURSES: If you are living in Queens County, N.Y., you are invited to join Queens County War Nurses Post of the American Legon. Write to the Commander, Miss Hilda Blom, 147-15 Sanford Ave., Flushing, N.Y., or to the Adjutant, Mrs. Antonia Minnick, 137-26 Centerville Ave., Ozone Park 16, N.Y.

PROVIDENCE HOSPITAL GRADS: The Alumnae Association is trying to bring its records up to date. If you have not contacted us in the past year, send your present name, maiden name and year of graduation to Anna D. Sloan, 4212-13th St. N.E., Washington 17, D.C.

THERESA BELLIVEAU: We met in Blendford, England, when you were at the 125th General Hospital (March, 1945). I believe you are now a hospital superintendent somewhere in Nebraska. Would you drop me a card? Helena Toews, c/o Dr. & Mrs. Gerhard J. Siemens, 1811 Jaffre St., Toledo, Ohio.

ANNA LARSON: Worked in Omaha, Nebraska, for three years about 1929. Your uncle Carl Engstrom, who says you are his only living relative in North America, would like to contact you. Ethel Dale, Matanuska Valley Hospital, Palmer, Alaska.

ETHEL BEARD ORME, MRS. CLARA BENTLEY, PEARL ADAMS OWENS, EVA HARTLEY, FLORENCE RAGAN COLT, ALENE COLE WARREN, ARDATH LINE, RUBY PALMO, GRACE WATERS RYMAN, LAURA BROWN GEORGE, ANNA DELANEY KUEUTZEN, MARGARET RHODD CARMAN, JOSEPHINE GRAMES CROAK, MARGARET NAY BLUME, EULALEA MOORE DAWS, LOUISE JOHNSON, HELEN LOWRY, MARY RUTH GREDELL CHOTEAU, ELLNORA MOORE, KATHERINE CRAY, MARY LOW MAIER ALIMISIS, MARY JANE BATEMEN GRIM, ANNA HITCHCOCK GRAHAM: Please contact Mary Ryan, President, St. Anthony Alumnae, 601 Northwest 9th St., Oklahoma City 3, Okla.

CATHERINE TWOMEY, JESSIE TURNER, HALLEEN HAYTHAUSAN: Hi, let's get together again, if only by letter. We have fond memories of you all. Stella Creel and Marion Truett, c/o Dr. B. Berkowitz, Bridgeton, N.J.

The Contest Winner

NOBODY CARES...

by Margaret C. Hilbert, R.N.

THE BOOKS LIST him as a great man of science whose discoveries have revolutionized surgery. Sentimental stories characterize him as modest and retiring. In the training school 25 years ago we called him old Ze-ze, and unhappy was the nurse who had to go and work with him.

One day it happened to me. "Report to the eye operating room," came the clipped orders of the supervisor as she read my name. We were standing in the assembly room at 6:30 in the morning, and I was not prepared for such a blow. Mac, who was being relieved of the job, punched me with her elbow. "Ze, ze, ze trouble iss nobody cares," she hissed and shook with gales of quiet, sadistic laughter. The supervisor was reading a list of complaints. A nurse had pinned her kerchief too low, had not handed in her laundry, had not made the corners of her bed at perfect right angles. Who could listen to such trivia before going to certain doom?

The nurse in charge was a student, for hospitals were always short of nurses, even in those days. Rumor had it that Nickie stayed on and on in charge of the O.R. because she was the only person in the whole place who was not afraid to talk back to old Ze-ze. That morning we cleaned the already clean room, while Nickie told me how simple all eye cases were. "There's nothing to it. He brings his own instruments and sterilizes them himself. All you have to do is stand and hand him what he wants with a forcep. Never touch anything with your hands, and don't drop anything. He hates bungling!"

"How do I know what he wants?" I argued. "I never saw an eye instrument in my life, and the ones we are going to use are not here now."

"Oh, he'll just yell," she said. "He forgets the names of them himself, but after the first case, you'll catch on."

The time for the operation arrived, and with it the patient, the doctors and old Ze-ze. He looked around and spied me at once. I had the white gown wrapped over my blue uniform, my hair covered and a mask over my face; but he knew that I was a stranger. "Who iss SHE?" he growled, hostility bristling from every pore.

"She is the new scrub nurse," said Nickie in sugary tones.

Guttural sounds came from deep within him, at last emerging in a mighty burst. "Take her away. I won't have another nurse. I won't

have her. I won't have her."

"Now, Doctor," said Nickie, "This nurse has worked with Dr. Brown. She knows all about eye work," she lied.

In acute distress, I was prepared to tear off my mask and run. Nickie made what was meant to be placating gestures and old Ze-ze merely resounded an ultimatum, "I won't work with her! Dr. Brown, what could she learn from Brown!" Then he seemed to forget me while he inspected the instrument table, the irrigator, the sterilizer and finally the closets that we had just cleaned. "Ze, ze, ze trouble iss, nobody cares," he muttered.

Nickie began showing me in pantomime what I was to do. Lift that towel; hold this solution basin; hand that glass tip—all with the forceps. The steaming instruments were on the table and the tiny needles and sutures were ready before me. Nickie had forgotten to tell me that I had to thread the needles. I could see well enough but who could have a steady hand with that old bear growling around and muttering as he waited. Dr. Smith, the young intern, saved the day by helping me thread the needles and by directing me with the slightest nod of the head or arch of the brow.

As the case went on old Ze-ze became another man. The noises and grumbling gave way to breathless silence. An aura of intense appreciation for the master craftsman's work seemed to surround him. He was an artist—and nothing existed but the work he was doing. As I watched I too could think only of the miracle I saw before me. As the tiny opaque lens of an eye slipped onto the minute spoon held by those deft fingers, I breathed again. Old Ze-ze heard me and glanced up to catch sight of the admiration that glowed above my mask.

"Dr. Brown," he growled, "he never did such a beautiful cataract, did he?" He didn't expect an answer. Dr. Smith helped me to pick the right sutures. Old Ze-ze went out with the patient to see him into his bed. I had lived through my first eye case.

The days that followed never were easy. Sometimes the tirades were worse than others, and always they ended on that hopeless note, "Ze, ze, ze trouble iss, nobody cares." Sometimes he told us stories of his early struggles in Vienna with a heavy kind of humor. To work with old Ze-ze was to learn to respect him and his ability and to know that the books were right. He was, in fact, a real scientist.

On New Year's Day old Ze-ze had to retire. He didn't seem that old. His hands were steady, his step was light, his shoulders straight and his work was perfect. [*Continued on page* 78]

ANNUITIES & RETIREMENT PLANS

PART II • by Virginia Harrell

WHERE DOES THE truth of the Harmon Plan lie? As usual, near the middle of the road. The Harmon Plan can't provide a rosy future for the nurse who invests $5 a month. Not, that is, unless you consider $25.60 a month pension enough for all your "rosy" needs. But it *is* the only annuity now available which was drafted solely for the nurse; it does offer a number of advantages you can't buy elsewhere and, in terms of the monthly pension you receive, the returns are as good, and in most cases better, than you can get from a commercial company. But the Harmon Plan also has its disadvantages. The wisest thing, therefore, is to sit down with a pencil and paper and analyze carefully your own needs; then you can determine whether Harmon or an individual annuity best solves your problem.

First, you will want to definitely decide on what you can pay each month toward an annuity. Choose a figure you are sure you can meet—even in an emergency—and then mentally reconcile yourself to living on your revised budget. It will probably mean trimming corners where you least want to, but once you've decided definitely on a sum you'll manage the adjustment. It's only when you halfheartedly make the decision, holding the mental reservation, "Well, if I get in a jam I can take it out of my savings," that you're liable to slide and, first thing you know, with your payments lapsed, your investment slips out of your hands.

Now that you've decided on the amount, it's time to make a comparison between the Harmon Plan and an individual annuity. W. Clifford Klenk, insurance consultant to the medical and dental profession, after a careful, exhaustive study of the Plan for R.N., gave it a clean bill of health as an investment. Further, he pointed out in its current favor that, with annuity rates as a whole steadily on the decrease, annuity offers now are not nearly so attractive as before the war, or even a few years ago. Harmon rates, however, have not decreased since 1941; thus, it now gives the nurse a better deal than practically any of the commercial policies which may have been

comparable to it in the year 1942.

According to Harold Pratt, Associate General Agent of John Hancock Insurance Agency of Boston, this reduction of annuity rates has two causes: First, the general lowering of interest rates; second, the fact that annuitants live longer due to their peace of mind, thus increasing the risk of the insurance company. Along this line, Mr. Pratt explains that a large percentage of the deaths of older persons are traced to worries of some kind. When an individual has the assurance that he will have a fixed income for the rest of his life, he just naturally relaxes and lives longer.

One point, however, at which the Harmon Plan has always been vulnerable to attack is the "non-profit" angle. It is true that the Harmon Foundation itself makes no profit but it doesn't sell non-profit insurance as its annuity policies are underwritten by a commercial company—the Metropolitan Life Insurance Company. What, then, does the R.N. get for her money that she couldn't purchase from a commercial company?

First, the Harmon Plan has a flexibility designed to meet the changes so inherent in a nurse's economic setup. That is, you can make your monthly payments as low as $5—or a multiple thereof. No commercial companies allow payments of less than $10 monthly. With Harmon, if your financial status improves you can increase your payments or, if you get in a tight spot financially, you can decrease them to as low as $5. Harmon prides itself on giving special consideration to any financial emergencies the R.N. must meet, and on the counseling service it offers for such problems. With Harmon, your retirement income may be taken at an age between 50 and 70. You can also get a cash refund on the entire sum you have invested at any time. Most commercial policies do not allow full cash refund until after the first ten or eleven year period. After that time, your cash refund from a commercial company is larger as the Harmon Plan does not allow any cash interest return on your payments. With Harmon, your money earns interest which is applied on your retirement income but if you turn in your annuity policy you only receive the amount you have paid, losing the earned interest which now is around 2¼ per cent. This is an important fact to keep in mind as many nurses have to turn in their policies before or near the age of 60.

To illustrate, there are comparative figures on the cash value of an annuity under the Harmon Plan and an annuity under one of the leading insurance companies whom we shall refer to as Company X. Each annuity allows for $10 a month payments by an R.N. from the time she is 30 years to her retirement at 60. (It might be well to remind you here of the sad fact that a woman does not get as favorable returns on annuities as a man as she lives five years longer, on an average.)

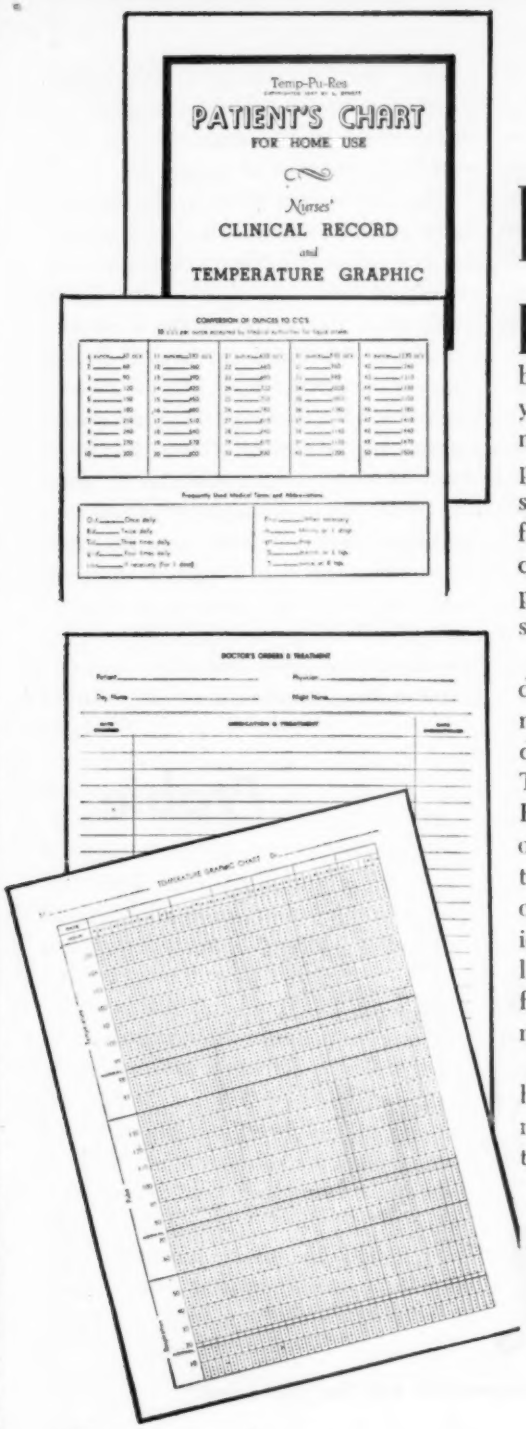
	Harmon	Company X
1 yr.	$120.00	$ 73.14
5 yr.	600.00	509.74
10 yr.	1,200.00	1,119.78
15 yr.	1,800.00	1,809.96
20 yr.	2,400.00	2,590.85
25 yr.	3,000.00	3,474.36
30 yr. (age 60)	3,600.00	4,473,95

You will note that after the 15 year period the cash value of the Company X policy surpasses the Harmon in increasing amounts until, at the 30 year period, the accrued interest amounts to $873.95 more than the sum offered by Harmon. This drawback of the Harmon Plan has been the target for much criticism in the past as there is quite probably no actual reason why your pre-retirement cash surrender value (not death benefit) should in any case involve a complete sacrifice of all interest earned by your own money. The Harmon Association explains that "compensation for this loss is found in all the other favorable terms of the policy, particularly the fact that you can withdraw the full amount of your cash in the early years, and that you receive the full refund at death instead of only a guaranteed number of installments which ordinarily do not equal the amount of deposits."

The latter point *is* in Harmon's favor as most commercial companies do not offer full death benefits to your beneficiary on rates comparable to those of Harmon. In the case of Company X's annuity, referred to above, taken in the form of a 10 Years Certain & Life, you receive an income for as long as you may live after retirement and, should you die before retirement, your beneficiary receives the equivalent of your annuity income payments for a period of ten years. If you die after you have started collecting your annuity, your beneficiary receives only ten years' benefits less [*Continued on page* 76]

Probie

"Something tells me we cleaned up the lab too soon."



FOR PRIVATE D

PRIVATE DUTY nurses—are you dissatisfied with the nurses' chart book you are using on your case? Do you think the present books on the market impractical or too incomplete for your use? Do you find yourself frequently carrying the expense for these books because of the psychological factor—patients' refusal to pay for an item they consider nurses' standard equipment? Yes?

Here's a tip. Out of the doodlings done during her patients' afternoon naps, Miss Luella Synott, private duty nurse, has come up with a Temp-Pu-Res Patient's Chart for Home Use. By the simple expedient of an effective change in title, and the addition of a few improvements over the current existing nurses' medical and fever charts, Miss Synott has literally removed an irritating thorn from the side of many private duty nurses.

These are the new features, tested by a trial run, and accepted by many nurses in New York City with enthusiasm:

1. Adequate hospital styled doctors' order sheets.

DUTY NURSES

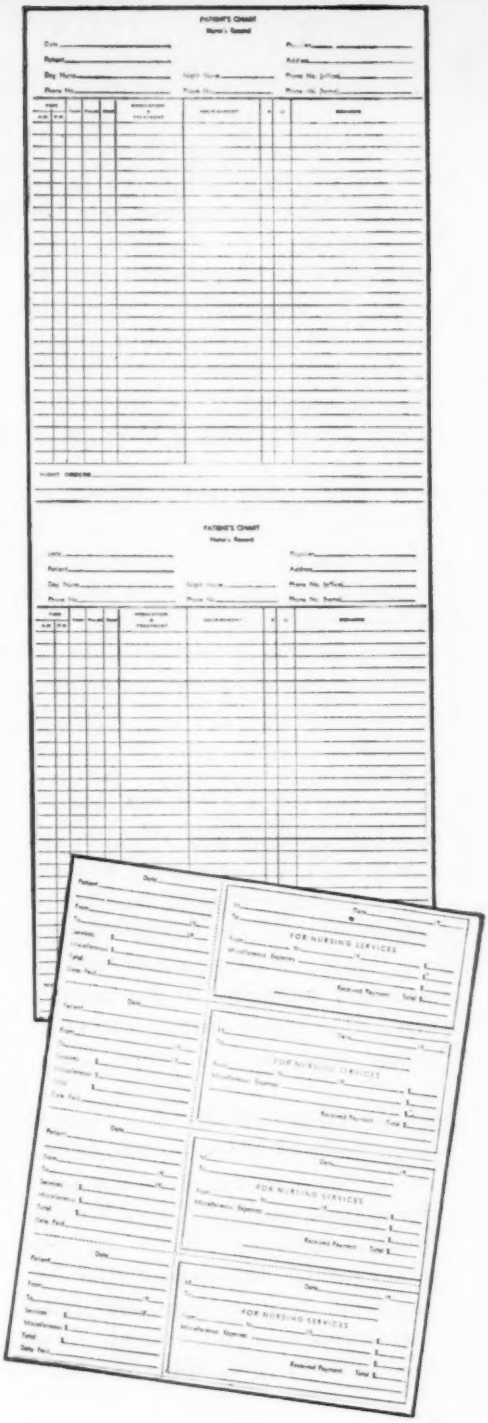
2. Simplified TPR graphics. No more necessity of that extra fountain pen filled with red ink.
3. Nurses' notes comparing favorably with those used in most hospitals.
4. And the piece de resistance, an attached blank receipt book—a sufficient supply for both day and night nurses for two weeks.

What happens when the patient no longer needs private duty nurses?

He keeps the unused portion for it is his, the patient's, chart. In case of extended care by someone in the family or practical nurse, the charts may continue to be of use. Or, the book may be stored away in the patient's home for such time as it may be needed again.

Where can these Temp-Pu-Res charts be purchased?

At any drug store where nurses supplies are handled, for they are being given wide national distribution. "If the stores don't handle them," says Miss Synott, "they should." She should know—she thought them up, she designed them, she sells them.



▶ "CLEAN HOUSE of the doctor chiselers who are overcharging veteran patients," Dr. Paul Magnusen, VA's new chief of medicine, asks the AMA. He warns that a list of the known and suspected unscrupulous medics will be submitted to the professional organization for appropriate action.

▶ A NEW ONE-ORGANIZATION PLAN for the structure of organized nursing has been agreed upon by the Committee on Structure of the National Nursing Organizations. The plan must first be submitted to the Boards of the six sponsoring national nursing organizations and, if found favorable, should soon be in the mails for public discussion. The Committee also approved the recommendation that would urge all states and districts to form committees on structure if they do not have them already. A committee member said: "The district structure committees will be extremely important in the formulation and eventual putting into effect of any new plan."

▶ THE RED CROSS may have to scrap national plans for free blood service because of a decision handed down from the New York County Medical Society. Officials of that group refused the request that employes of business firms and other organizations be allowed to "bank their blood" free for their own benefit and that of their families. They explained the refusal on the grounds that all processing and testing of blood should be done under the direction of specialists and apparently felt that the Red Cross did not qualify on this point.

▶ GREAT BRITAIN'S MAN in the street says "Yes" to Aneurin Bevan's health plan but over 89 per cent of the doctors voted emphatically "No." With public pressure solidly behind them, the Labor Government plans to go ahead anyway with the new program providing free medical and dental services for everyone who needs the care.

▶ MAJOR HELEN C. BURNS has been appointed by the Army Surgeon General as the Assistant Director of the new Women's Medical Specialist Corps and Chief of the Dietitian Section of that Corps. With her appointment came a promotion to the rank of Lieutenant Colonel, the highest rank ever held by an Army dietitian.

▶ OLEOMARGARINE MAY COMPETE FREELY on the market again if House hearings now in progress are favorable to repealing the exorbitant tax imposed on it. Continued high prices of butter and consumer resistance have forced legislation.

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Add 2% Illinois Retailers' Tax on purchases to be delivered in Illinois. Postage extra outside our regular delivery zone. Sec. 20 48

Citizenship

[*Continued from page* 27]

often come *after* the convention when there is more time for study.

The delegate, however, should not vote until she knows what she is voting for. She should have the courage to delay the vote if necessary until her information and consultation with her colleagues enables her to vote intelligently. At the 1946 Biennial, the President brought out in her report the comprehensive ANA program for Economic Security. This was followed by a motion to "consider" the points in the program. A delegate from Georgia, misunderstanding the motion, objected: "My objection to the consideration at this time is because we go into action so soon without having heard many things we need to know before making a decision."

It was a mistake on her part for the motion was for "consideration" only and not "action." However, this healthy attitude of waiting for "the many things we need to know" is essential to every major move of the House, regardless of how full may be the agenda. There are ethical as well as practical considerations involved.

For every delegate there are questions to ask of oneself:

1. Do I realize the responsibilities as well as the privileges of serving as delegate? Will I keep in mind that I am voting on actions that affect the whole profession . . . actions that are legally and morally binding?
2. Will I therefore learn to the best of my ability what is the prevailing opinion on the proposed changes in the By-Laws, the proposed approach to the one-organization plan broached by the Structure Committee, and on other major issues announced in advance?
3. Will I refrain from voting on unannounced proposals until my information on the subjects is sufficient to make my decision a sound one?
4. Do I know my ANA By-Laws—especially those relating to Biennial Conventions?

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Rest is Prescribed

[*Continued from page* 36]

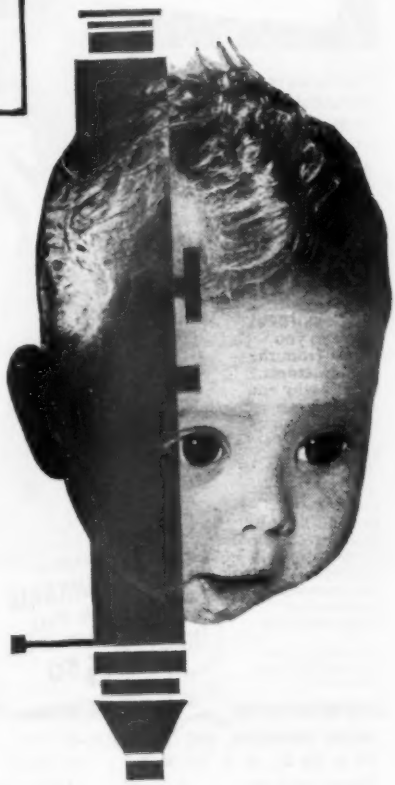
care should be taken constantly to include the patient in as many of the household activities as possible. Some of the prosaic tasks of preparing food can be made important tasks for the child. Even inexperienced little hands can cut cookies and the child who is old enough may help with such preparations as shelling nuts and peas, and peeling potatoes. Granted, the mother could accomplish these tasks more quickly herself, but there is a definite value to including the young patient in the household routine.

Education should be stressed during the convalescent stage. In many cities, and some rural districts, this is taken care of by a home or visiting teacher. If a teacher is not available, the parents should take the responsibility so the child will be better able to keep up with the children of his own age when he returns to school and the time he has been ill will not be wasted. Even in cases where the parents are perfectly capable of teaching their child, a teacher going into the home relieves the monotony of confinement and provides a link with the outside world.

Physical activity, as well as mental, is a factor in the convalescent period, but the graduated physical activity should be directed by the physician. Craft activities are stressed at this point and it is quite possible that a child can be started on an activity that will continue for life. [*Turn the page*]

antiseptic baby oil used by 3400 hospitals

inhibits growth of common skin pyogens on newborn babies



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* Potter, Raymond T. and Abel, Arthur R., "A Study of Surface Bacteria of the Newborn and the Comparative Value of Cleansing Agents," American Journal of Obstetrics and Gynecology 31, No. 6, 1936.

Findings of the Moore Clinical Laboratory on Antiseptic Properties of Various Oils for the Skin of Babies.

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Shorthand is a good occupation for the person who must limit his physical activity; sewing, crocheting, knitting or dressmaking can all be developed into professions. An interest in plants, developed in the sick room, may lead into an interest in horticulture. One little boy learned to mend toys. Such an interest could lead to toy making or cabinet work and lighter types of carpentry.

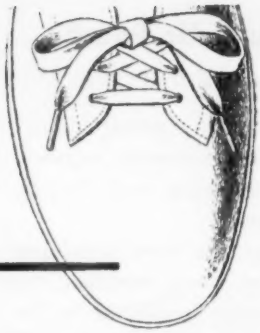
The child with artistic ability could develop it into the many branches of commercial drawing and designing, painting, or sculpturing.

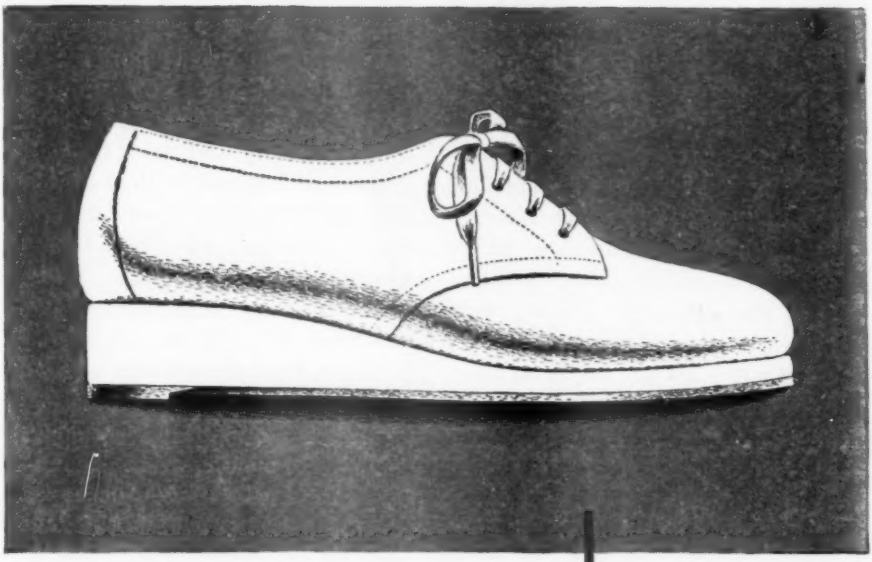
Hobbies play an important part in a child's life. Collecting such things as coins, stamps and buttons can be made more a "live" activity if the child corresponds with other children, starting his list of "pen pals" by writing to children's magazines.

For the child who enjoys simple creative work there is a type of modeling wax that is used like clay, but is cleaner. Ordinary materials in the house, such as corks and thumb tacks, can be used to make "critters." Wise mothers and nurses also comb children's magazines for pages of puzzles, hand work and coloring.

The difficulty with nursing rheumatic fever children is that during convalescence they do not look like invalids and often do not feel like invalids. Youthful exuberance for nearly every normal activity must be tempered. It's a job for the nurse to keep her young patient content with modeling clay when his playmates are playing football out of doors. Her heart is in the job, though, for she knows his heart depends on it.

Alert in White





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Rheumatic Family

[*Continued from page* 37]

moved the dining room furniture out, and bedroom furniture and boy in. The dining room became another sick room.

Next, the boys developed the sore swollen joints, nodules, rash and all the symptoms listed in the books. I had read everything I could find pertaining to the disease. Some days one or the other would start crying with pain long before daybreak. I rubbed the sore limbs and wrapped them in strips of old woolen blankets, which I warmed before applying. Sometimes I would no sooner get one joint rubbed and wrapped than another would need attention. Often both boys would be wanting attention at the same time. There were days when I didn't wash a dish all day, let alone eat my meals on time. I ate supper at 9 or 10 o'clock at night, then washed all the dishes and cleaned the kitchen after that.

Things, however, finally arranged themselves into some sort of routine; that is, after I had made up my mind that the children and their care came first and if the housework did get out of hand, I was not going to be too upset about it. I was doing everything I could, even making allergy breads and cookies, and planning the allergy diets, for the younger boy was on a strict allergy diet the whole time he was in bed and the older boy, a greater part of the time.

The problem of going out arose. The doctor had said I must go out some myself, so after about six weeks I decided I wanted to see a certain motion picture. The boys and I had talked about my going out, but when I was ready to leave they both cried. So their daddy told them that when I went out I would be their eyes and ears and would tell them about the funny pictures and other things I saw and heard. Realizing that this would give us new food for conversation, they fell in with the plan.

When I did go out, I found it difficult to go any place where I'd meet people. I was definitely *not* in a mood for their endless questionings, curiosity and words of pity which they expressed by saying, "My, and you can still smile." (After the boys had been in bed 14 or 16 months this

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became monotonous.) My stock answer number 999 was, "You should see the boys—they are the ones in bed and *they* keep smiling."

Whenever it was possible, we hired a reliable woman to stay with the children while my husband and I went out together. Those occasions were real treats and much needed diversions for both of us.

In this account so far, it probably appears as if they were model children. No—we had clashes of wills, temper tantrums, obstinacy, tears and every other thing that mothers with well children run into. But, we have tried to show our boys that even though they were confined to bed temporarily, life was not just going to be handed to them on a tray, so to speak, as their meals were. They were made to realize that they had certain responsibilities, even though those had to be of limited variety and had to learn to accept them graciously. They were taught that there needs to be a certain amount on the give side and not all on the take side, which can easily happen when children or adults have to be in bed and waited on constantly.

Any nurse who has cared for a child on a rainy day knows the problem of entertaining him for even a short time. It is this sort of thing, day after day, month in and month out, which confronts parents of bedfast rheumatic fever children. Children's interest span is so short. It becomes doubly hard because children with rheumatic fever are not allowed to engage in any of the activities where the arm and chest muscles are in-

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volved to any great extent, so entertainment is a problem. Of course, each child is an individual and the physician is the one to say what and how much the child may safely do. Games that do not excite must be chosen and even radio programs must be selected.

Finally, after 20 months in bed my boys' tests were normal and they were allowed to sit in a chair for five minutes, then ten and gradually more. Finally they were allowed to take a step, and when they were allowed to walk to the table for one meal it was a festive occasion for all of us.

Later they were allowed to dress. Then more activity was added slowly. Now after 26 months, they have activity in the house, with a two-hour rest period in the afternoon.

People say, "How did you ever manage?" But when a job is given us to do, somehow God gives us strength to see it through, and if, by keeping my boys in bed all that time, their hearts have been spared damage I will say gratefully; every single minute, every single heartache it has caused will be considered a glorious gain to give my children their birthright of healthy bodies. I am thankful for my nurse's training and experience which has helped in so many ways, and for the understanding doctor who stood by.

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"beforehand" extra—

TRUSHAY

Belgian Congo

[*Continued from page* 43]

will not thrive in the tropical climate, bedbugs will, and Miss Bateman's latest war has been waged against them. She writes:

"Thanks to a friend at home I was sent enough money to buy DDT powder for all the stations. The natives complain so much about the bugs that when it came I began on their beds. I've done all the 75 beds in the dormitories, 78 in the workmen's rows, seven in the widows' home and still have some left for the beds of the schoolboys. I had quite a following of little folk as I went from house to house. They thought it was a lot of fun."

Although the community is still very primitive, the Western ideas are more and more in evidence. Most of the houses are constructed of sun baked mud with palm thatched roofs and dirt floors but now an increasing number of brick houses are being built.

Their material belongings are extremely simple. Miss Bateman says some of them have fairly good beds, "if you call boards and grass mats a bed." One enterprising man, a hunter, has an especially fancy bed. His, has a real wooden frame with one layer of springs woven from inch-wide strips of antelope skin. Under the leather springs, he has tied six real springs that he found somewhere.

Some of these people have blankets or a sheet and, fortunately, most of them have mosquito nets. A few have tin trunks to keep their belongings away from the white ants. Most families also have a bamboo table, a few dishes and maybe a glass, plate, and knife or spoon for each member of the family. The men eat their one or two daily meals from the table while the women still must follow the ancient custom of eating in the kitchen, a small hut in back of the house. These huts are still built too low for adequate standing headroom so the women do all their work and eating crouched on a low stool or sitting on a grass mat.

Western civilization is slowly pushing back the boundaries of the jungle in the Belgian Congo. Along with DDT and modern obstetrical meth-

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ods, even football has been introduced to the community. Miss Bateman wrote: "The boys are having fun playing football and are developing a school spirit. They play against a company post about two miles from here. Of course they are disappointed if they lose and pepped up if they win. Their cheering may not be as scientific as it is at home but it is just as effective and much more expressive."

From voodoo charms to football and DDT is a long, slow process of education but Miss Bateman has the patience of all good missionaries and teachers. Her anchoring philosophy in this little-penetrated section of the world is best summed up in her own words:

"The world wasn't made in a day so we can't make over these people's customs in a day. Over the door as I go into the ward I often find hidden charms, made of palm leaves, a stick or pith from some reed—just enough to make them feel more secure. Of course I can see the uselessness of these charms, but as they cannot serve two gods, we have a chance for more teachings of God's love and protection. Perhaps this in time can replace the fear of the evil spirit—a spirit seeking to destroy rather than doing constructive good."

Statistical calculations in the Annals Eugenics *show that advancing maternal age bears a significant relationship to the incidence of anencephaly, spina bifida and congenital hydrocephaly.*

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Bedford Springs — Bedford, Mass.

PHN Role in Spokane

[*Continued from page* 39]

conditions," Dr. Fischer said. "We are slow to brand any child as having rheumatic fever, but once definitely diagnosed, we tell the child."

Older children become familiar enough with the procedure to ask: "What was my 'sed' rate?" The sedimentation rate is an indication of degree of bacterial activity in the body and, while by no means diagnostic of rheumatic fever, it is a useful measuring stick of the progress of the disease when considered with temperature graph, pulse and weight.

Public health nurses conduct a post-clinic conference with each mother, after the doctor's examination. The nurse makes sure that the mother understands the doctor's recommendations, and clarifies any technical language.

"Rest and observation is 90 per cent of the recommended program for rheumatic fever," Dr. Fischer repeats. The mission of the public health nurse is to arouse the enthusiastic cooperation of mother and child for all details of the program. Keeping an accurate rectal temperature graph is such a detail and is most important.

"Return in two weeks" is interpreted by giving the mother an exact return appointment. She also will be mailed a postcard reminder. Where the doctor so orders or the nurse recognizes as advisable, the mother is referred to the clinic nutritionist. Also, the nurse may give information about the relation of bad tonsils to

"Two are an army to one"

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rheumatic fever, if the doctor has advised tonsillectomy.

The public health nurse makes sure that all recommendations can be financed. Cod liver oil or iron preparations may be provided by the county health department. If the nurse discovers any need for financial advice, or if any doubts exist in the nurse's mind about the parent's acceptance of the diagnosis and recommendations, the parent is referred to the medical-social worker. When parents can pay part of the hospitalization cost, the medical-social worker reaches an agreement with them on the amount. The Federal and state rheumatic fever money formerly paid all or part of the hospitalization cost for many children.

"But the funds for our rheumatic fever program have been drastically cut," Miss Hudson explained. "We've had to send many of our children home from the hospital and from our convalescent home before they were ready to go. Six months from now, a year from now, we will be seeing the difficulties which will follow this curtailment of advisable care."

A cut by the Washington State legislature in the total amount requested by the State Department of Health cut the funds available for the State Crippled Children's program including care of orthopedic, spastic and rheumatic fever children. In addition, hospital rates have gone up from $7.38 to $12.10 a day. This has resulted in practically halting the hospitalization part of the rheumatic fever program. [*Turn the page*]

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If the public health nurse is not satisfied with the post-clinic conference with the mother, she makes a home call to go over the program again. The county nurses do not give bedside care except as a teaching demonstration. They do try to equip each mother for ministering any home nursing that is required.

Before the clinic, Dr. Fischer makes rounds of the hospitalized rheumatic fever children, accompanied by Miss Hudson and the pediatrics supervisor, so that the public health nurses are constantly in touch with the patients.

After the child goes home, public health nurses check to be sure the mother follows instructions. They watch for the slightest indication of relapse and make sure that child and mother come for checkups.

Dr. Fischer listed four major duties, as he sees it, of a public health nurse in a rheumatic fever program: **(1)** to educate the community and arouse it to early recognition of rheumatic fever; **(2)** to find cases; **(3)** to assist with actual clinic; **(4)** and to coordinate care at hospital, convalescent home and the child's own home.

Full credit is given the public health nurses in Spokane County by Dr. Fischer. In summing up their role in the Washington State fight against this disease, he has said, "Early finding of cases and careful follow-up are two of the chief assets in the whole rheumatic fever program. These public health nurses are doing a superior job on both these phases."

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Annuities

[*Continued from page* 49]

the total number of the years already paid you. Thus, if you have collected for eight years, your beneficiary receives two years' benefits; if you have collected 11 years, your beneficiary receives none.

On the ledger side, Company X allows on this annuity seven optional methods of receiving your income. You need not select your method until you are ready to retire; then you can choose the one best suited to your circumstances. Since none of us can forecast our future, this is quite an asset.

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You probably have one last question. What is the difference in monthly pension amounts between the Harmon annuity and that of Company X? They are about the same. Again, let's take the case of a nurse who at age 30 commences paying $10 a month to the Harmon Plan. At her retirement age of 60 she would receive $307.10 annually or $26.50 a month. With the annuity of Company X she would receive $23.58 a month. Strictly speaking, the $2.02 difference between these two pensions is equalized by the $2 membership fee which every Harmon policy holder pays yearly.

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Napoleon meddled with medicines, mixing all kinds of tonics to be later presented to lady friends.

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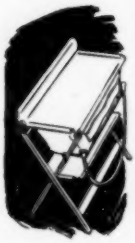

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Nobody Cares

[*Continued from page* 46]

Nickie took the day off and I was left alone to bring in all the patients for dressing. When other men retired, the hospital made quite an affair of their last rounds. Friends and associates came in crowds to walk past the white beds for the last time with the retiring doctor. Cases were discussed, charts were read and stories told. Nurses and supervisors danced attendance. Sad good-byes were said. Some of these men were mere appendix-snatchers, pill-rollers, saw-bones as compared to a scientist like old Ze-ze.

Who would come to see him on his last rounds, I wondered, as I brought the patients into the dressing room? Old Ze-ze, whose name had been in "Who's Who in Medicine" since he was 27! Who was coming to honor this truly great scientist?

The patients were waiting; the dressing trays were ready; Dr. Smith was there. We heard the sharp click of heels as old Ze-ze came down the corridor at the exact time he was expected. His step was firm and his back was straight. He was alone. He started dressings as usual. Little Tony was improved. The bandages were removed from Mrs. Berger. Yes, she could see light; now it was only a matter of time and the right glasses. Old Ze-ze started dictating orders to Dr. Smith. He stopped short. "I forgot," he laughed, "tomorrow you will take orders from Dr. Brown. I waste my time." Still he continued with the most minute directions for the care

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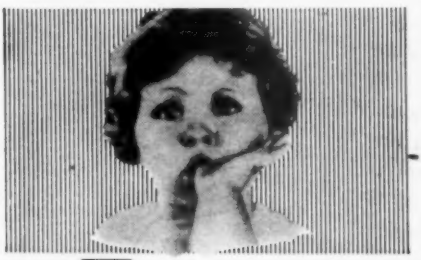
of his patients. When he finished he stood by the door; he bowed to us; to me, to Dr. Smith and to the patients with their eyes swathed in bandages.

"Good day," he said, "take good care of my patients. Good day," and he was gone. We watched him as he walked down the corridor to the coat room. He was leaving the hospital for the last time. Was no one coming to say "thank you" for his many years of service? He who had made it possible for the blind to see! He who had changed surgery from a thing of horror to a painless blessing. Was no one coming; not even from the office?

I looked at Dr. Smith; Dr. Smith looked at me. We were not smiling when we said in unison, "Ze, ze, ze trouble iss, nobody cares."



USE THUM TO DISCOURAGE

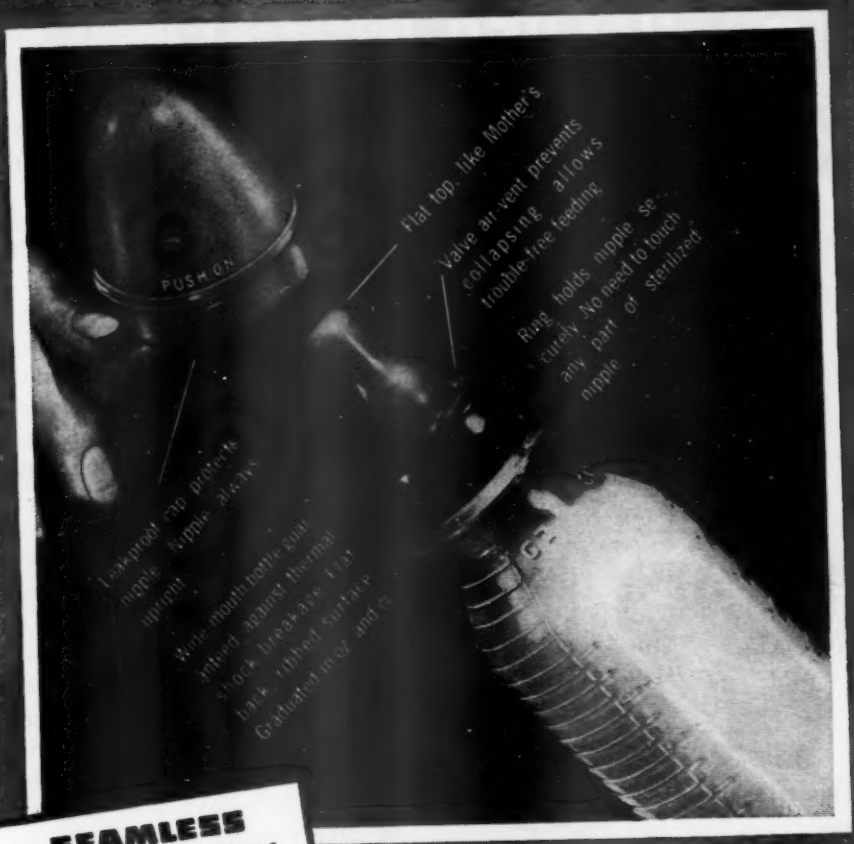
thumb sucking ... nail biting

Have a Heart

[*Continued from page* 33]

that a child in a typical "rheumatic family" will also get the disease. The case differs from the "tuberculous family" in that the rheumatic fever patient has to be protected from the family, whereas with tuberculosis the family has to be protected from the patient. The difference actually lies in the fact that new attacks of rheumatic fever can be induced by re-infection with hemolytic streptococcus. Rheumatic fever itself is not contagious.

Another point of disagreement concerns climate. It has been said of the rheumatic fever patient that wherever he goes, he will have to stay. Supposedly, the disease is most prevalent in the temperate zone, in cold, wet seasons of the year. Take the patient South? Yes, but he will have to stay there or risk re-infection upon returning to a colder climate. Climate, though, cannot provide the ultimate answer for the strange paradox has existed of two towns, side by side, being affected differently by the disease. Oddly, too, the two regions showing the greatest number of rheumatic fever cases are widely separated—New England and the Rocky Mountain states. The warmer sections of the U.S. seem to be the least affected by the disease, yet records show that these same Southerners have a much greater susceptibility if they move to northern cities. Most doctors now believe that it is not worth the trouble of uprooting families and sending them South. A



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majority advise good personal health under proper medical care and a good community public health program which will be the most valuable of all for present and future rheumatic fever patients.

The classical treatment for rheumatic fever has come to be "long rest in bed under good medical and nursing supervision." This theory has come under fire recently by doctors with fairly reasonable evidence to show that long convalescence may be more damaging than a short period. They point out that keeping patients in bed for months at a time may in itself make cripples of the patients—physically and mentally. In a cautious trial at a military physical-fitness laboratory in Texas, the average length of convalescence was cut from 77 to 16 days, apparently to the benefit of the patients. Other figures cite that under the usual system of long convalescence, the period can be from 30 to 255 days—an average of four months. Whether or not a shorter period of convalescence can be instituted will still depend on the individual. Absolute freedom of activity will probably never be possible for the patient with serious heart damage. In these cases supervision is needed to prevent cardiac patients from overexertion and to guard against recurrent attacks.

Only recently has it been recognized that the course of rheumatic fever can dramatically reverse itself. For the future, natural recovery may be depended on to a much greater extent than formerly thought possible. Surgery, mitral valvulotomy,

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was in vogue a few years ago, but records show now that much of it is unnecessary if further attacks of rheumatic fever can be prevented. Coronary heart disease has also shown a tendency to spontaneous recovery. One doctor points out, though, that this possibility must not deter scientists from seeking "better and more scientific treatment."

The outlook for complete recovery of rheumatic fever patients is not too bright. The real "cure" will have to be prevention. Forty-three per cent of all children with rheumatic fever will be able to complete their lives with normal activity; 20 per cent will have slight limitations put on their activities; less than 15 per cent will have drastic limitations and 20 per cent will die of the initial attack or die within ten years. Good medical care, of course, increases the chance for recovery.

"Good medical care" can best be given in hospitals or sanitoriums, according to the doctors. Economically, this is not feasible, for the families of most rheumatic fever patients are already in the lower economic group. Home care for these young patients means going back to crowded conditions and poor diets—the same that probably was responsible in the first place. The heart associations and civic groups are making it part of their programs to correct this vicious cycle. Special hospitals and clinics are being planned and an attempt is being made at formulating a successful system of foster-home care.

Federal and state aid for the care of rheumatic fever children has only


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come into being during the last ten years. The first Federal aid was given in 1939 as part of the grant in the crippled children's program. Oklahoma had the first program of joint Federal-state aid, approved by the Children's Bureau in 1940. Seven years later, 20 other such programs were under way and 12 more were in the planning stage. These figures are actually deceiving for the catch is that only two of these programs are *statewide*. Limited funds, limited hospitals and limited nursing services mean that these programs actually affect only 300 of the 3,000 counties in the U.S. Even in these counties all the children are not able to take advantage of the facilities—again because of limited facilities and personnel.

Last year Federal funds amounted to $1,250,000 for support of these programs. This was twice as much as was available during any previous year but it was still only a drop in the unfathomable bucket. *Thirty times that much annually* will be necessary if the problem is to be met with a nationwide frontal attack.

The American Heart Association is one of the groups working with the Children's Bureau on the rheumatic fever problem. Under the guidance of the American Heart Association, the Council on Rheumatic Fever was set up in 1944. It is working for the extension of public programs and carrying out privately supported study and educational work. It is for the support of these rheumatic fever programs that you are asked to "Have a Heart." DOLLIE C. CARPENTER

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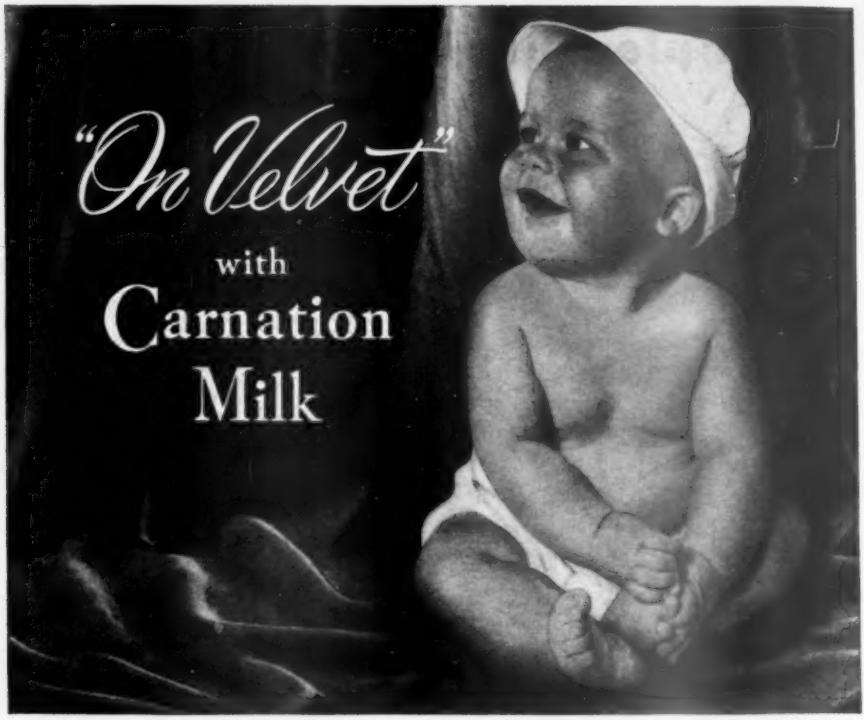

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GENERAL DUTY NURSES: Pennsylvania. Selected surgical department, Philadelphia teaching hospital. Base pay $160 with full maintenance; 44-hour week; straight 8-hour duty. Apply: Dr. Charles P. Bailey, 218 Runnymede Ave., Jenkintown, Pa.

GENERAL DUTY NURSES: New Jersey. Eight-hour shifts. Apply: Director of Nursing, Newcomb Hospital, Vineland, N.J.

GENERAL DUTY NURSES: Texas. Meals, laundry, hospitalization, two weeks vacation given. Salary for day shift $160, afternoon duty $175, night duty $190. Apply: Southwestern General Hospital, 2001 Erie St., El Paso, Tex.

GENERAL DUTY NURSES: North Jersey. Vacation, sick leave, hospitalization insurance are given nurses at this 156-bed general hosptal; 8-hour duty, 6-day week; $130 with full maintenance, $160, live out; 10 per cent increase after six months. Apply: Director of Nursing Service, Morristown Memorial Hospital, Morristown, N.J.

GENERAL DUTY NURSES: Virginia. For labor and delivery room; nursery and central supply; also medical-surgical nurses; $145, maintenance; $165, one meal and laundry; $5 additional for 3-11 and 11-7 shifts; vacation. Apply: Supt. of Nursing, Alexandria Hospital, Alexandria, Va.

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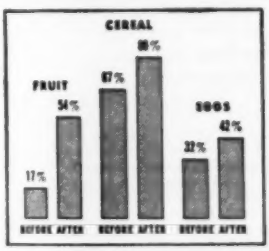

This graph shows the percentages of children's breakfasts that included certain food groups before and after one year of emphasis on nutrition.

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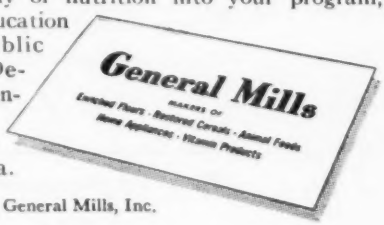

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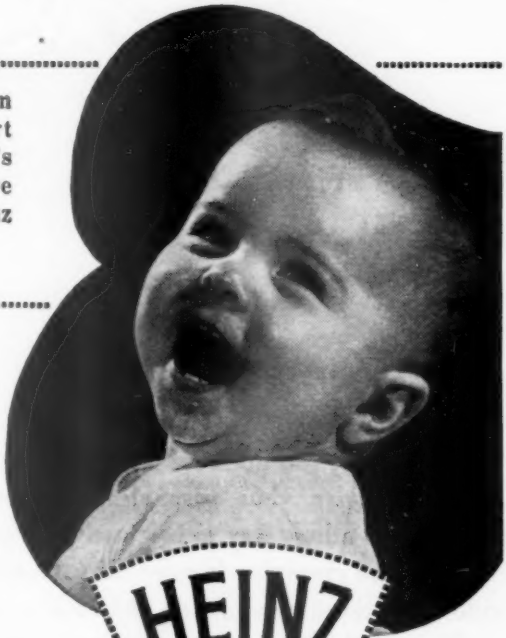

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